The Journal

of the Michigan State Medical Society

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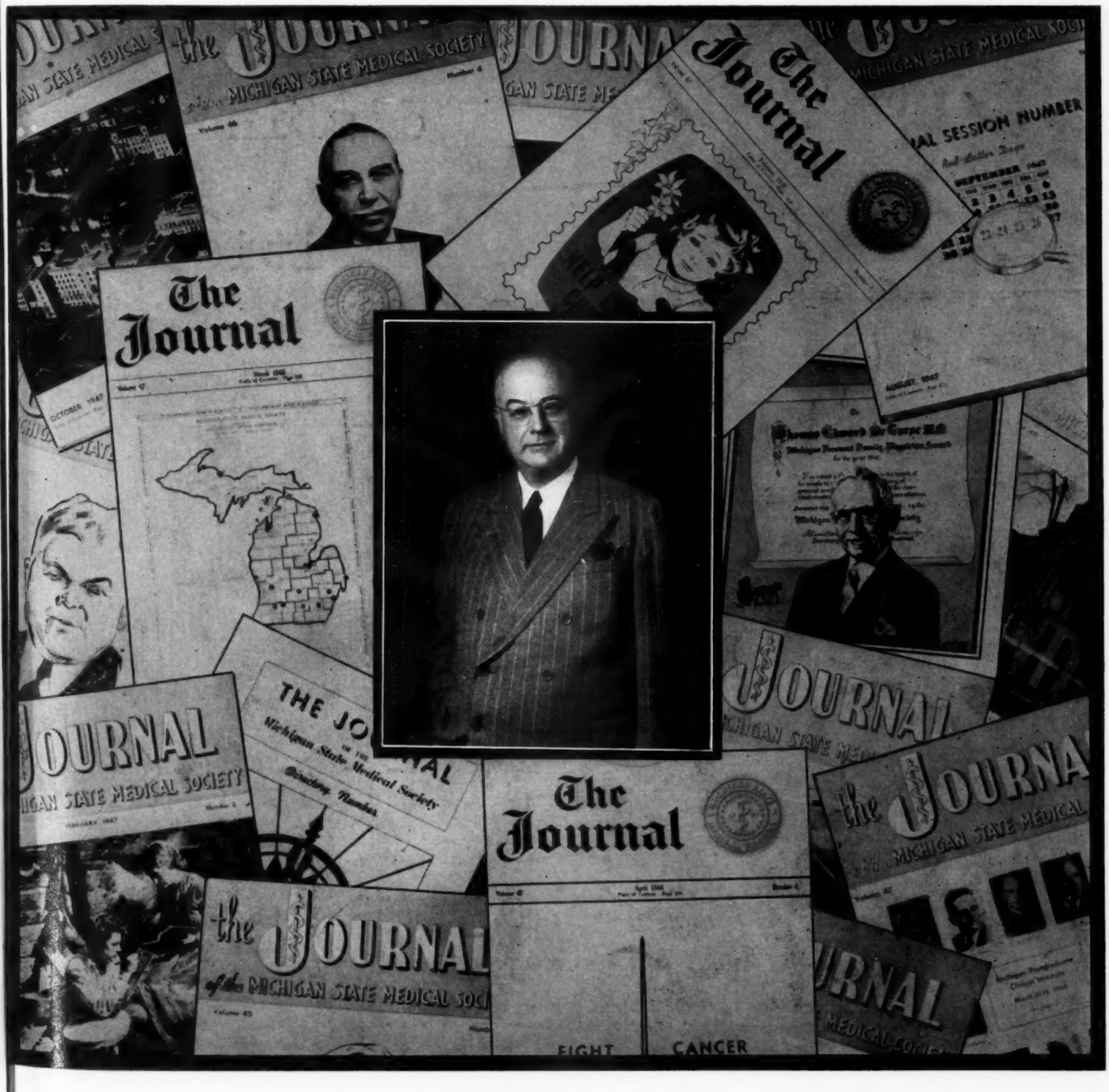

EDITOR WILFRID HAUGHEY, M.D.

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

We're telling Mothers to ask you about the Mother's Oats benefits of this new baby cereal. (Mother's Oats and Quaker Oats are the same.)

Typical Analysis of Baby Quaker Oatmeal	Per Ounce
Protein	15.1%
Fat	7.2%
Carbohydrate	64.1%
Fiber	1.7%
Total Minerals (Ash)	4.6%
Calories	108
Calcium	230 mg.
Phosphorus	277 mg.
Iron	6.6 mg.
Thiamine	0.44 mg.
Riboflavin	0.063 mg.
Niacin	0.406 mg.

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Cancer Comment

THE DETROIT CANCER CENTER

An event of more than local significance occurred on April 20, 1948, when the Detroit Cancer Center was formally dedicated. The remodeled building at John R and Hancock Streets will serve all the cancer activities in the metropolitan Detroit area as well as provide laboratory space for the Detroit Institute of Cancer Research.

The building is owned by the Michigan Cancer Foundation, a nonprofit organization acting as trustee for contributions to those phases of the cancer control program that do not fall within the scope of the American Cancer Society's activities. Already, substantial sums have been given for preparing the building for its present uses, among them that of the Variety Club composed of motion picture theatre owners and operators whose assistance was recognized by the unveiling of a plaque in its honor at the dedicatory ceremonies.

The Southeastern Michigan Division of the American Cancer Society, representing, Macomb, Oakland and Wayne Counties, will have its headquarters in the building for carrying on its extensive educational and service programs. Under auspices of this organization eight cancer detection centers are operating in various Detroit hospitals and it is intended to open an additional center in the new headquarters in the near future.

The Center will also furnish facilities for an enlarged lay and professional educational program in a meeting room with a capacity of 200 or more. At the dedication ceremonies it was announced that next October a three-day cancer institute would be offered to the medical profession of Michigan and adjoining areas.

The Detroit Institute of Cancer Research will occupy quarters on the second floor where space is available for twenty-five workers. The research program which has been under way for several years in temporary quarters provided by Wayne University Medical School, has been focussed on some of the biological problems concerned with cancer etiology. Ample quarters are available for laboratory animals and it is the present intention to devote some time to breeding animals of definite biological strains for controlled cancer experiments. Laboratories will be equipped for isotope and biophysics studies.

Organization of the Detroit Institute of Cancer Research in 1942 was due to the energy and vision of the late Rollin H. Stevens, M. D. whose specialty of radiology threw him in close contact with the cancer problem for many years. He felt the definite need for additional facilities for cancer research and devoted the last years of his life to developing the idea of such a research center in Detroit. Due to the war it was impossible to proceed with plans for a permanent home for the Institute during his lifetime. The present building and the activities it houses will be a fitting memorial to his untiring interest in the problem of cancer research and control.

The Detroit Cancer Center is probably the first institution of its kind to emerge from the greatly expanded co-operative program that has been developed in the last few years between scientific and lay individuals and groups. It is planned to co-ordinate its research program with the larger program on cancer research now supervised by the National Research Council and subsidized by the American Cancer Society. Nearly 200 research projects are being studied in this co-ordinated program which is devoted, in the main, to investigation of the biological and physical factors concerned with the process of growth.

LYMPHOID TUMORS

Lymphoid tumors if untreated will invariably result in the death of the patient. The onset of the disease is insidious. Enlargement of the lymph nodes of the neck —the first symptom—frequently follows an upper respiratory infection. Symptoms include weakness, fatigue, loss of weight, and pain which is indicative of advanced disease. Ten per cent of the patients show bone involvement.

"Early diagnosis and treatment of lymphoid tumors constitute the only approach to a successful outcome in this disease," the doctors write. "Our efforts should be bent toward this end, namely, to establish the diagnosis of the disease while it is still localized and then to deliver an obliterative dose of radiation treatment."—*Radiology,* May, 1948.

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Michigan Postgraduate Clinical Institute

Record Attendance at 1948 P.G. Institute

Postgraduate credits: one unit of credit for each day of postgraduate attendance was given every member of the Michigan State Medical Society registering at the second annual Michigan Postgraduate Clinical Institute. The following MSMS members registered.

Registrations for March 10, 1948

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R. G. Jackson, Ann Arbor; A. H. Jacoby, Bay City; C. N. Jaekel, Detroit; Louis Jaffe, Detroit; Robert C. Jeremias, Detroit; Hubert R. John, Detroit; E. B. Johnson, Allegan; Kenneth H. Johnson, Lansing; Orlen J. Johnson, Bay City; Ralph A. Johnson, Detroit; E. V. Joinville, Detroit; L. Faunt Jones, Detroit; Joseph F. Juliar, Mt. Clemens.

Ned Kalder, Detroit; Roland E. Kalmbach, Lansing; L. E. Kamin, Detroit; Z. L. Kaminski, Detroit; N. J. Kapetansky, Detroit; Herbert S. Karr, Detroit; Irwin G. Karrow, Northville; I. S. Katzman, Detroit; D. H. Kaump, Detroit; Cecilia S. Kay, Muskegon; Thomas F. Keating, Detroit; Henry J. Kehoe, Detroit; Victor A. Kelmenson, Detroit; Lee E. Kelsey, Lakeview; R. M. Kempton, Saginaw, James M. Kennary, Detroit; Chas. S. Kennedy, Detroit; Donald J. Kennedy, Detroit; Donald C. Kent, Eloise; Fanny H. Kenyon, Lansing; W. H. Kern, Garden City; James T. Keyes, Birch Run; C. R. Keyport, Grayling; M. J. King, Detroit; J. G. Kirker, Detroit; John H. Kitchel, Grand Haven; David Kliger, Detroit; E. J. Knobloch, Detroit; Edward J. Koerber, Detroit; C. S. Kogut, Detroit; Joseph O. Kopel, Detroit; A. Koven, Detroit; Geo. E. Kreinbring, Detroit; F. Krynicki, Detroit; F. S. Kucmierz, Detroit; Chester H. Kulaski, Detroit.

Paul Craig Laird, Detroit; L. W. Lang, Detroit; H. B. Larzelere, Flint; L. Ross, Leaver, Detroit; P. L. Ledwidge, Detroit; George Q. Lee, Detroit; Charles E. Lemmon, Detroit; Luther R. Lender, Detroit; Nicholas Lentini, Cheboygan; Hartman A. Lichtwardt, Detroit; Harry Lieffers, Grand Rapids; J. H. Lewis, Wyandotte; R. W. Lignell, Detroit; Geo. H. Livingston, Highland Park; C. E. Lockwood, Holly; Stewart Lofdahl, Nashville; E. Clarkson Long, Detroit; John J. Long, Detroit; John J. Loomis, Muskegon; James Louisell, Hamtramck; Adolf W. Lowe, Detroit; George L. Lowry, Detroit; F. E. Ludwig, Port Huron; L. Mason Lyons, Detroit.

A. D. McAlpine, Detroit; R. E. McBroom, Detroit; J. J. McClintock, Detroit; K. M. McColl, Detroit; L. R. McElmurry, Lansing; A. W. McGarvah, Detroit; J. A. McGarvah, Detroit; R. W. McGeoch, Monroe; N. D. McGlaughlin, Wyandotte; J. McGough, Detroit; William B. McIntyre, Detroit; B. E. McNamara, Lansing; Howard H. McNeill, Pontiac; J. A. MacDonell, Dearborn; W. W. MacGregor, Detroit; Earle D. MacKenzie, Detroit; Malcolm D. MacQueen, Detroit; Ralph C. Magnell, Detroit; Clarence E. Maguire, Detroit; Hugh M. Mahoney, Detroit; F. P. Maibauer, Wyandotte; V. S. Mancuso, Detroit; Everett R. Maresh, Detroit; Francis L. Markey, Saginaw; R. Markoe, Detroit; Michael M. Marolla, Northville; R. G. Marsh, Tecumseh; James R. Marshall, Detroit; E. G. Martin, Detroit; Wm. P. Martzowka, Saginaw; Brooker L. Masters, Fremont; C. J. Mathes, Detroit; Emil V. Mayer, Detroit; Frederick M. Maynard, Allen Park; W. A. Maynard, Coleman; William H. Meade, Lansing; Marvin B. Meengs, Muskegon; Walter A. Meier, Howell; Albert H. Meinke, Eaton Rapids; E. H. Meisel, Midland; Maxim P. Melnik, Detroit; R. J. Mendelssohn, Detroit; C. M. Mercer, Battle Creek; Capt. Hyman Merlin, Fort Custer; Maurice Meyers, Detroit; Michael J. Michael, Detroit; Hugh H. Miley, Detroit; Myron H. Miller, Detroit; Clinton C. Mills, Detroit; Morris J. Mintz, Detroit; Gertrude F. Mitchell, Detroit; O. W. Mitton, East Tawas; Robert C. Moehlig, Detroit; V. P. Moisides, Detroit; Clarence D. Moll, Detroit; Robert C. Monson, Detroit; Joseph R. Montanto, Detroit; A. R. Moon, Saginaw; Coleman Mopper, Detroit; R. S. Morrish, Flint; Max M. Mosen, Detroit; E. C. Mosier, Otisville; N. H. Moss, Detroit; John B. Moyer, Eloise; Edwin B. Mueller, Northville; H. F. Mullenmeister, Battle Creek; Fred E. Murphy, Traverse City; Scipio G. Murphy, Detroit; William A. Murray, Detroit.

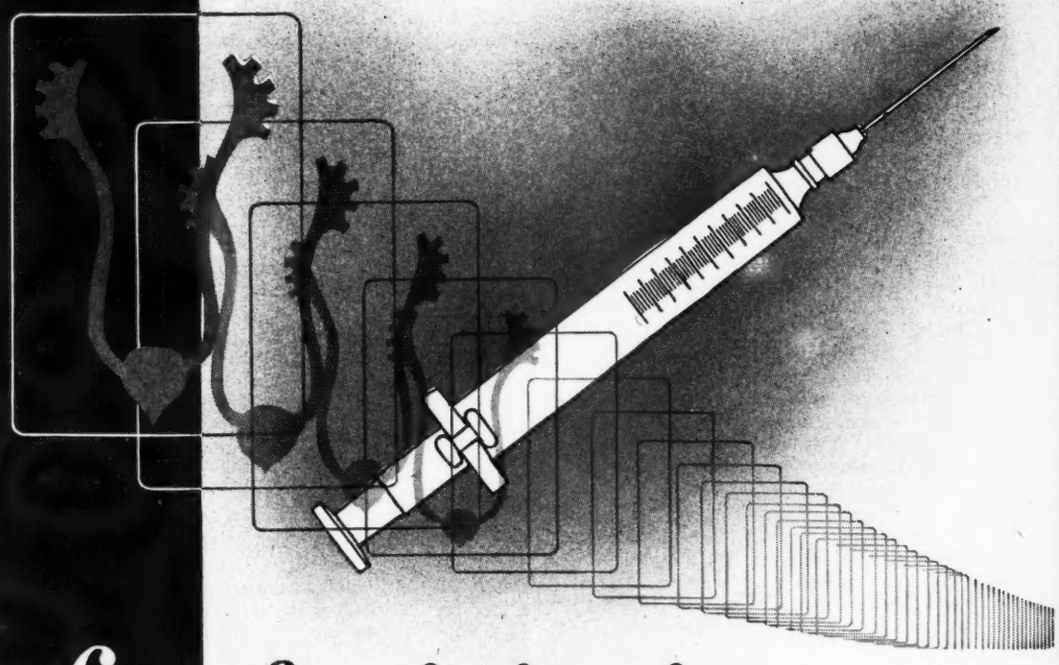
James W. Nann, Highland Park; A. H. Naylor, Detroit; A. J. Neumann, Detroit; Arnold Best Newcomb, Berkley; Mildred V. Nicholas, Saginaw; I. D. Nickerson, Highland Park; Marco Nobili, Detroit; P. B. Northouse, Grand Rapids; John Norup, Berkley; Joseph J. Nosanchuk, Pontiac.

D. J. O'Brien, Lapeer; Ira D. Odle, Flint; Dayton O'Donnell, Detroit; Alex Olen, Detroit; Edwin G. Olmstead, Battle Creek; C. F. Oman, Detroit; Charles Ornstein, Detroit; Eugene A. Osius, Detroit; Mark F. Osterlin, Traverse City; Clarence I. Owen, Detroit.

A. A. Palmer, Chelsea; Benjamin R. Parker, Detroit; Theo. H. Pauli, Pontiac; H. A. Paysner, Detroit; Grover C. Penberthy, Detroit; S. C. Petix, Detroit; G. N. Petroff, Detroit; Philip S. Peven, Detroit; Frank L. Pierce, Detroit; F. P. Pina, Northville; Karl G. Pinckard, Dearborn; Edwin H. Place, Lansing; J. D. Plekker, Grand Rapids; R. C. Pochert, Owosso; J. W. Podezwa, Detroit; L. I. Powers, Muskegon; H. J. Prall, Lansing; Lawrence A. Pratt, Detroit; Robert H. Proud, Flat Rock.

E. C. Raabe, Morenci; R. M. Ragan, Flint; R. L. Rapport, Flint; Harold F. Raynor, Detroit; Howard C. Rees, Detroit; A. T. Rehn, Lapeer; J. J. Reichman, Mt. Clemens; Wells C. Reid, Goodrich; Ernest R. Reinsh, Detroit; Leo P. Rennell, Detroit; Wm. F. Reus, Grand Rapids; W. S. Reveno, Detroit; John W. Rice, Jackson; Paul J. Rick, Detroit; G. H. Rigterink, Kalmazoo; Edward L. Robb, Detroit; Herbert F. Robb, Belleville; J. M. Robb, Detroit; A. J. Roberts, Lincoln Park; R. G. Robinson, Detroit; O. F. Aoeglin, Detroit; A. S. Rogoff, Detroit; Paul C. Rohde, Detroit; Robert Rosen, Detroit;

(Continued on Page 590)



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(Continued from Page 588)

J. D. Rosenman, Detroit; Samuel Rosenthal, Highland Park; Felix F. Rosenwach, Detroit; Saul Rosenzweig, Detroit; Donald G. Ross, Grosse Pointe; M. S. Rowda, Detroit; Peter Rowe, Ann Arbor; J. J. Rucker, Detroit; Ralph C. Rueger, Detroit; Edward F. Runge, Dearborn; Emil F. Rupprecht, Detroit.

H. J. St. Amour, Detroit; Paul T. Salchow, Detroit; John N. Salowich, Allen Park; G. B. Saltonstall, Charlevoix; Susanne M. Sanderson, Detroit; William R. Sargent, Detroit; Walter W. Sawyer, Hillsdale; Philip P. Sayre, Onsted; David Scheer, Detroit; R. Rudolph Scheidt, Lansing; A. J. Schenden, Melvindale; Sydney Scher, Mt. Clemens; John H. Schlemer, Detroit; Robert F. Schultz, Detroit; Stanley V. Sciarrino, Detroit; Robert D. Scott, Flint; E. W. Secord, Detroit; Ward F. Seeley, Detroit; Reuben I. Seime, Ypsilanti; J. H. Selman, Detroit; George Sewell, Detroit; M. L. Shadley, Pontiac; E. M. Shafarman, Detroit; Loren W. Shaffer, Detroit; L. O. Shantz, Flint; J. Shapiro, Detroit; John Sheldon, Ann Arbor; M. D. Sheridan, Detroit; Louis Shiovitz, Detroit; Norman R. Shippey, Eloise; W. H. Shipton, Detroit; B. Shlain, Detroit; Carlos W. Shotwell, Detroit; Wm. A. Siefert, Detroit; Israel Z. Silvarman, Detroit; I. Walter Silver, Detroit; Maurice M. Silverman, Detroit; Max Silverman, Detroit; Emil R. Simon, Detroit; C. E. Simpson, Detroit; Floyd W. Singer, Dearborn; Nelson Singer, Detroit; Geo. W. Sippola, Detroit; John M. Sisson, Detroit; E. F. Sladek, Traverse City; Milton E. Slagh, Saranac; Vincent E. Slahetka, Detroit; Leo W. Slazinski, Detroit; Henry Small, Detroit; Ward M. Smathers, Fort Custer; A. R. Smeck, Detroit; Donald S. Smith, Pontiac; Henry L. Smith, Detroit; M. B. Sofen, Kalmazoo; Edward D. Spalding, Detroit; H. I. Sparling, Northville; Irene L. Sparling, Northville; Adolph Spiro, Detroit; B. R. Springborn, Detroit; Carl J. Sprunk, Detroit; Meyer Stamell, Detroit; A. C. Standler, Saginaw; Myron R. Stanton, Detroit; Wm. J. Stapleton, Jr., Detroit; Monte G. Steadman, Fort Custer; Albert H. Stein, Detroit; Emory Stein, Detroit; James R. Stein, Ferndale; Saul C. Stein, Van Dyke; Stanley R. Steinbach, Fort Custer; M. J. Steinhardt, Detroit; Harry L. Stern, Detroit; Louis D. Stern, Detroit; John J. Stewart, Detroit; Dwight E. Stith, Detroit; Martin E. Strand, Dearborn; H. D. Stricker, Detroit; Fred L. Strickroot, Detroit; A. W. Strom, Hillsdale; C. K. Stroup, Flint; C. G. Stucky, Charlotte, Edwin C. Sundell, Pontiac; Donald N. Sweeny, Jr., Detroit; Karl L. Swift, Detroit; B. C. Switzer, Detroit; J. C. Szejda, Detroit.

Cecil E. Tate, Jackson, Malcolm J. Tear, Detroit; Rudolph G. Tenerowicz, Hamtramck; E. C. Texter, Detroit; E. L. Thirlby, Traverse City; H. E. Thompson, Detroit; M. J. Thorstad, Detroit; E. C. Timmerman, Coopersville; Arthur C. Tompsett, Hesperia; Frank M. Townsend, Detroit; W. D. Towsley, Midland; A. J. Tranella, Detroit; George A. Troester, Detroit; Henry Turkel, Detroit; Jack V. Turnbull, Dearborn; M. G. Turner, Flint.

Willis H. Ulrich, Detroit; C. E. Umphrey, Detroit; William K. Usher, Grosse Pointe.

Henry J. VandenBerg, Grand Rapids; William O. VandenBerg, Detroit; James E. Van Eck, Detroit; George Van Rhee, Detroit; V. O. Vasu, Detroit; J. R. Venema, Grand Rapids; V. K. Volk, Saginaw.

Joseph E. G. Waddington, Detroit; Darwin E. Wagoner, Lincoln; Michael Wainstock, Detroit; Enos G. Walker, Detroit; Arch Walls, Detroit; Pei-Jen Wang, Detroit; Howace F. W. Warden, Detroit; Robert W. Watson, Detroit; M. A. Wayne, Detroit; Karl W. Weber, Detroit; Lynn F. Webber, Northville; Kathryn D. Weburg, Petoskey; Herbert Wechsler, Ann Arbor; Jacob Weinstein, Detroit; Allen Weisberg, Detroit; Irvin Weisenthal, Detroit; Casimir P. Weiss, Detroit; Jack I. Weiss, Van Dyke; Harry L. Weitz, Traverse City; Kenneth N. Wells, Spring Lake; Merrill Wells, Grand Rapids; Horace L. Weston, Detroit; Robert G. Wetterstroem, Northville; R. R. Whitter, Ionia; T. W. Wienczewski, Alpena; Israel Wiener, Detroit; Morton J. Wiener, Detroit; Ralph D. Wigent, Pontiac; F. B. Wight, Detroit; M. M. Wilde, Warren; A. J. Williams, Detroit; John P. Williams, Pontiac; Gordon L. Willoughby, Flint; Gerald A. Wilson, Detroit; Walter J. Wilson, Jr., Detroit; Edw. A. Wishropp, Detroit; Arthur A. Wittenberg, Detroit; M. Witus, Detroit; Walter M. Whitehouse, Howell; Helen W. Wollank, Detroit; Kenneth A. Wood, Detroit; J. B. Woods, Fraser; J. J. Woods, Ypsilanti; W. E. Woods, Detroit; William P. Woodworth, Detroit; W. R. Wreggit, Highland Park; C. H. Wright, Detroit; D. R. Wright, Flint.

William J. Yott, Detroit.

E. J. Zabiwsfi, Detroit; Joseph Zbikowski, Detroit; H. B. Zemmer, Lapeer; Chas. J. Zielinski, Detroit; Margaret H. Zolen, Kalamazoo; Carl R. Zolliker, Imlay City; S. A. Zukowski Detroit; Maurice L. Zunder, Detroit.

Registrations for March 11, 1948

U. M. Adams, Marcellus; R. G. Alexander, Lansing; F. S. Alfenito, Grand Rapids; Samuel S. Allen, Jr., Lapeer; J. K. Altland, Lansing; Jerome W. Ankley, Detroit; H. B. Appelman, Detroit; R. J. Arrington, Detroit; H. S. Asselstine, Detroit; R. M. Atchinson, Northville.

Harry E. Bagley, Dearborn; F. J. Balaga, Detroit; O. F. Banting, Richmond; Herbert G. Barak, Kalamazoo; Louis L. Barnett, Detroit; Morrison D. Beers, Detroit; Henri Belanger, River Rouge; Wm. M. Bell, Detroit; George W. Bennett, Elsie; Robert J. Bernucci, Detroit; Frank B. Bicknell, Detroit; G. Clare Bishop, Almont; N. M. Bittrich, Detroit; James R. Blakeney, Auburn Heights; L. C. Blakey, Monroe; E. W. Blanchard, Deckerville; Arthur W. Boddie, Detroit; L. F. Boddie, Detroit; C. J. Bogucki Highland Park; Carl F. Boothby, Hartford; Andrew H. Bracken, Dearborn; Robert M. Bradley, Flint; O. A. Brines, Detroit; William Bromme, Detroit; F. W. Brown, Jr., Lansing; Gordon T. Brown, Detroit; Karl B. Brucker, Lansing; A. S. Brunk, Detroit; John Bryce, Detroit; John D. Buck, Detroit; J. H. Buell, Detroit; J. E. Burnett, Jr., Detroit; Howard B. Burnside, River Rouge; Julius Y. Burnstine, Detroit; M. Buskirk, Midland; R. W. Buxton, Ann Arbor; G. W. Byington, Detroit; F. G. Buesser, Detroit.

Henry W. Cadieux, Detroit; E. W. Caster, Detroit; Fred E. Caumartin, Detroit; Hugh Caumartin, Detroit; R. A. Charleston, Detroit; L. G. Christian, Lansing; Harry L. Clark, Detroit; Ronald E. Clark, Detroit; James A. Cook, Detroit; Burton R. Corbus, Grand Rapids; Joseph M. Croman, Mt. Clemens; Victor Curatolo, Detroit.

Esther H. Dale, Detroit; A. J. Degasn, Detroit; T. E. DeGurse, Marine City; Isla G. DePree, Grand Rapids; C. F. Derebinski, Muskegon; Panfilo C. DiLoreto, Detroit; W. J. Dinnen, Detroit; E. F. Dittmer, Detroit; Frederick W. Dixon, Dearborn; Charles F. Dodenhoff, Detroit; W. R. Doering, Detroit; Harold T. Donahue, Cass City; Douglas Donald, Detroit; Ben C. Dorniak, Detroit; John M. Dorsey, Detroit; E. J. Dudzinski, New Baltimore; C. E. Dunn, Detroit.

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ATTENDANCE 1948 P.G. INSTITUTE

(Continued from Page 590)

Chas. C. Eades, Detroit; B. R. Elliott, Ovid; Nicholas J. Ellis, Croswell; Otto K. Engelke. Ann Arbor; Clyde Ensign, Plymouth; D. C. Ensign, Detroit; A. R. Ernst, Saginaw; L. S. Evans, Detroit.

T. S. Fandrich, Detroit; Leon Fill, Detroit; Alvis D. Finch, Detroit; Robert E. Finton, Jackson; Max First, Highland Park; E. W. Fitzgerald, Port Huron; Robert G. Fogt, Detroit; J. R. Forsythe, Detroit; Wm. L. Foster, Detroit; R. A. Frary, Monroe; Mary Margaret Frazer, Detroit; Donald K. Freeman, Detroit.

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R. L. Haas, Ann Arbor; Hilda A. Habenicht, Jackson; William A. Haley, Detroit; A. C. Hall, Detroit; A. Edith Hall-Kent, Lansing; Frederick E. Hansen, Detroit; Joshua Hanser, Detroit; Geo. C. Hardie, Jackson; R. John Hardstaff, Detroit; William H. Harrison, Lansing; L. C. Hart, Lansing; R. K. Hart, Croswell; O. J. Hastings, Detroit; Louis F. Hayes, Detroit; R. J. Himmelberger, Lansing; A. J. Hollander, Detroit; R. R. Howlett, Caro; L. W. Hull, Detroit; T. H. Hunt, Detroit; Daniel D. Hurst, Pleasant Ridge; W. G. Hutchinson, Bloomfield Hills; John R. Hyland, Detroit.

Arthur Isaacson, Detroit.

T. J. Jamieson, Lincoln Park; Wm. G. Jend, Detroit; A. Esther Johnson, Monroe.

Walter Kapleta, Hamtramck; Louis L. Kazdan, Detroit; Harther L. Keim; Detroit; Kelly Keith, Highland Park; Hardy A. Kemp, Detroit; Herbert K. Kent, Lansing; Edward D. King, Detroit; C. Kirchgeorg, Frankenmuth; John A. Kleber, Detroit; Earl J. Knaggs, Wyandotte; Byron S. Knapp, River Rouge; Lyle W. Korum, Detroit; John C. Kretzschmar, Detroit; Albert A. Kuhn, Detroit; Chester H. Kulaski, Detroit.

Edward C. Lake, Detroit; John S. Lambie, Pontiac; B. H. Larsson, Detroit; Edward H. Lass, Lapeer; Philip L. Lathrop, Detroit; Edward H. Lauppe, Detroit; James Lauridsen, Port Huron; R. W. Lawson, Detroit; A. F. Lecklider, Detroit; S. E. Lerman, Van Dyke; Elmore F. Lewis, Jackson; James Lightbody, Detroit; Richard H. Lillie, Ann Arbor; Geo. D. Livingston, Detroit; James W. Logie, Grand Rapids; Norman O. LoMarche, Detroit; Joseph H. Lorber, Detroit; M. C. Loree, Lansing; R. T. Lossman, Traverse City; Henry A. Luce, Detroit; John R. Lukas, Detroit; Russell E. Lynch, Center Line.

D. H. McGinnis, Detroit; B. T. Malachowski, Detroit; Karl D. Malcolm, Ann Arbor; Joseph M. Markel, Dearborn; Joseph P. Markey, Saginaw; Clyde S. Martin, Port Huron; Lyndle R. Martin, Detroit; H. A. Meinecke, Detroit; W. E. Mercer, East Lansing; Chas. C. Merkel Grosse Pointe; Byrd F. Merrill, Detroit; Earl G. Merritt, Detroit; E. B. Miller, Detroit; J. A. Morley, Detroit; W. H. Morrison, Goodrich; Robert J. Morrow, Lansing; P. T. Mulligan, Mt. Clemens; N. D. Munro, Jackson.

Harry M. Nelson, Detroit; Rudolf J. Noer, Detroit.

Francis P. O'Linn, Detroit; John E. Orebsugh, Ann Arbor.

Matthew Peelen, Kalamazoo; Grace M. Perdue, Detroit; Z. R. Peterson, Detroit; A. C. Pfeifer, Mt. Morris; Homer A. Phillips, Saginaw; Kenneth C. Pierce, Dowagiac; Robert S. Pollack, Detroit; H. M. Pollard, Ann Arbor; Harry Portnoy, Detroit; E. C. Potter, Lansing; Wm. F. Powers, Detroit.

Henry K. Ransom, Ann Arbor; F. E. Reeder, Flint; J. G. Reid, Detroit; Lawrence Reynolds, Detroit; F. P. Rhoades, Detroit; C. J. Richards, Durand; Allan L. Richardson, Detroit; Herman H. Riecker, Ann Arbor; Robert Riethmiller, Detroit; Frank Rizzo, Grosse Pointe; S. C. Robins, Detroit; William D. Robinson, Ann Arbor J. D. Rogers, Adrian; C. Howard Ross, Ann Arbor; Hyman Ross, Detroit; Leon Rottenberg, Detroit; John B. Rowe, Flint; A. D. Ruedemann, Detroit.

Anthony G. Sack, Detroit; E. O. Sage, Detroit; Edward L. Sager, Detroit; John T. Sample, Saginaw; Donald V. Sargent, Saginaw; W. A. Sautter, Horton; C. A. Scheurer, Pigeon; Edna Schrick, Holland; R. J. Screen, Farmington; Leland D. Shaeffer, Detroit; Reuben I. Shapiro, Detroit; Charles H. Sharrer, Detroit; B. H. Shepard, Lowell; A. P. Shewchuck, Allen Park; Irving E. Silverman, Lansing; J. W. Sinclair, Detroit; Fred M. Slaughter, Detroit; John G. Slevin, Detroit; Clarence V. Smith, Detroit; Ferriss Smith, Grand Rapids; James M. Smith, Detroit; E. Spurrier, Detroit; Hugh Stalker, Grosse Pointe; Ernest L. Stefani, Detroit; S. D. Steiner, Lansing; Floyd H. Steinman, Flint; George D. Stilwill, Flint; Claire L. Straith, Detroit; P. C. Strauss, Lansing; Milton B. Stuecheli, Detroit; H. Saul Sugar, Detroit; Cullen E. Sugg, Grand Rapids; Neil Sullenberger, Pontiac; M. V. Susskind, Jackson.

J. C. Tapert, Detroit; G. A. Tatelis, Detroit; Aaron Taylor, Detroit; John Ten Have, Grand Rapids; William J. Thaler, Detroit; Daniel C. Thomson, Ann Arbor; Ledyard H. Tomlinson, Newport; K. W. Toothaker, Lansing; H. A. Towsley, Ann Arbor; Bryan Trombley, Detroit; F. L. Troost, Holt; Paul K. Truba, Detroit; Keith M. Truemner, Detroit; S. W. Trythall, Detroit.

R. W. Ullrich, Mt. Clemens.

R. S. Van Bree, Grand Rapids; T. P. VanderZalm, Lansing; James E. Van Eck, Detroit; Frank Van Schoick, Jackson; J. D. Van Schoick, Hanover; Edward M. Vardon, Detroit; H. E. Vergosen, Detroit; Edward E. Vivirski, Jackson; Milton D. Vokes, Detroit; Heide E. C. Vonder, Detroit.

R. W. Waggoner, Ann Arbor; Perry V. Wagley, Pontiac; Everal M. Wakeman, Dearborn; Irving A. Warren, Detroit; John E. Webster, Detroit; John H. Welch, Detroit; Martha Wells, Detroit; J. F. Wenzel, Detroit; Charles J. Westover, Plymouth; A. H. Wittaker, Detroit; Harold W. Wiley, Lansing; Harry E. Windiate, Pontiac; Andrew G. Wilson, Detroit; William G. Winter, Holland; Joseph A. Witter, Detroit; Lance S. Wright, Wayne; Charles A. Wunsch, Detroit.

Arthur J. W. Yates, Detroit; J. P. Yegge, Kent City.

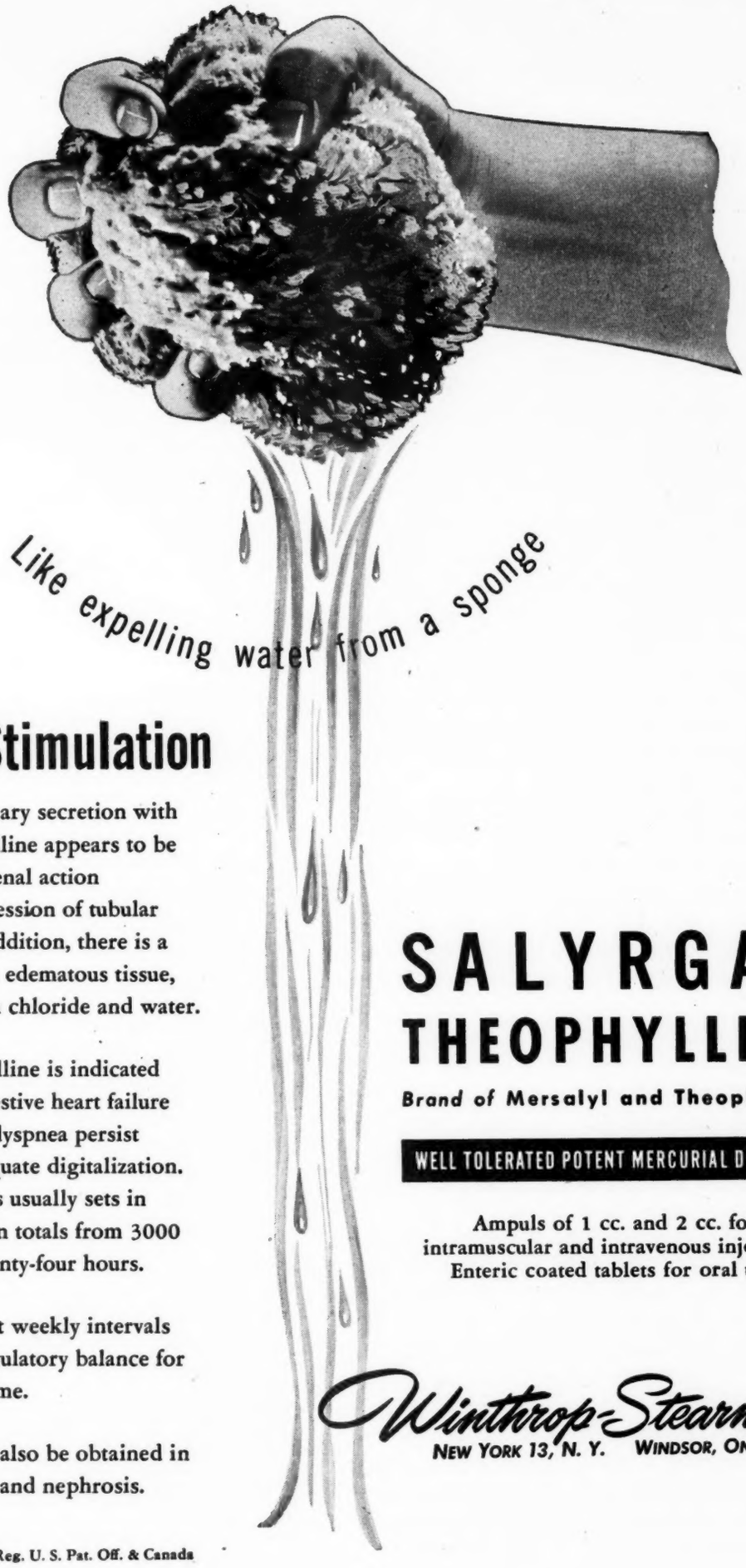
Registrations for March 12, 1948

Sidney L. Adelson, Detroit; Allen Alexander, Detroit; C. P. Anderson, Eloise; H. B. Appelman, Detroit; James W. Armbruster, Detroit; Lawrence R. Atler, Detroit; LeRoy L. Atler, Detroit; Ira Avrin, Detroit.

Arthur G. Baker, Allegan; C. D. Barrett, Eloise; S. K. Beigler, Detroit; J. E. Berry, Detroit; G. A. Brough, Detroit; Samuel M. Brown, Detroit; Loren G. Burt, Flint; Harry J. Butler, Detroit.

L. C. Chang, Northville; C. P. Clark, Flint; Donald V. Clark, Detroit; George J. Curry, Flint; John M. Czuj, Detroit.

(Continued on Page 594)



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Senator Vandenberg Tells Premier Stalin

At the Michigan Congressional Dinner in Washington on April 26, Senator Arthur H. Vandenberg said he wanted to tell Premier Stalin of Russia that "underlying everything else we shall not surrender to Communist conspiracies in the United States."

"We are suicidal fools if we do not root out any treason at home which may dream of bringing world revolution to the United States. The United States cannot accept a Munich peace because appeasers merely precipitate the very disasters from which they seek to flee."

While reiterating the Nation's desire for peace, Senator Vandenberg said: "We are realists. We do not propose to be isolated in a world that has been communized by force."

Senator Vandenberg remarked that a lasting peace must be based on justice and freedom and must protect the survival of western civilization. While the United States does not covet an inch of territory or a dollar of reparations, he said, it responds with its resources to help other nations who believe in the democratic way of life and are in need.

The Senator emphasized the United States' willingness to co-operate with Russia in achieving a just peace, but he said "We cannot be driven or coerced into positions we decline to assume."

This nation, he added, will not bargain with human rights and fundamental liberty.

At the dinner, given in honor of Senators Vandenberg and Ferguson and Michigan's seventeen Congressmen, the Michigan State Medical Society was represented by L. Fernald Foster, M.D., Bay City, L. W. Hull, M.D., Detroit, and R. J. Hubbell, M.D., Kalamazoo. The Wayne County Medical Society was represented by C. L. Candler, M.D., Detroit, and the Bay County Medical Society sent A. D. Allen, M.D., Bay City.

An interesting sidelight of the dinner was the enthusiastic meeting of Senator Ferguson by Mr. Lowell B. Genebach of Battle Creek. Mr. Genebach introduced himself to the Senator as the father of Ferguson's first appointee to West Point in 1944.

Senator Ferguson stated, "I am glad to meet the father of my first appointee, but I have yet to meet the appointee."

Selections to West Point are not political in Senator Ferguson's book.

Attendance 1948 P.G. Institute

(Continued from Page 592)

M. J. Dardas, Bay City; G. E. Davidson, Detroit; Geo. C. DeSmyter, Detroit; Max E. Dodds, Flint; Donald Drolett, Ann Arbor; John J. Dudek, Detroit; F. W. Dwyer, Detroit.

A. F. Fath, Kalamazoo; F. S. Fordell, Detroit; Merle S. French, Paw Paw, A. C. Furstenberg, Ann Arbor.

David B. Gaberman, Detroit; Watson A. Gilpin, Detroit; Samuel Gingold, Detroit; Wm. S. Gladstone, Flint; F. Gordon Grant, Detroit.

A. J. Hamilton, Flint; Foster Hampton, Jr., Detroit; Lawrence Harrington, Detroit; F. W. Hartman, Detroit; Louis E. Heideman, Detroit; Horace B. Holloway, Detroit; Henry T. Holt, Grosse Pointe Woods; George B. Hoops, Detroit; Harold A. Horkins, Detroit; Philip J. Howard, Detroit; W. L. Howard, Northville.

J. F. Jellema, Detroit; F. N. Johnson, Detroit; R. E. Johnson, Flint; W. H. M. Johnson, Detroit; W. S. Jones, Menominee.

Mana Kessler, Bay City; H. F. Kilborn, Ithaca; Walter W. Kitti, Detroit; Lewis L. Kline, Detroit; M. D. Klopfenstein, Northville; M. E. Kohn, Detroit.

M. L. Lichter, Melvindale; A. G. Liddicoat, Detroit; James Lousell, Detroit.

G. T. McKean, Detroit; James J. McClendon, Detroit; Richard M. McKean, Detroit; Kenneth E. Mapletoft, Detroit; M. H. Marks, Detroit; K. E. Markuson, East Lansing; Robt. J. Mason, Birmingham; Richard H. Meade, Jr., Grand Rapids; George Mogill, Detroit; F. L. Morris, Cass City; H. L. Morris, Detroit; Charles Wayne Moulton, Detroit; A. P. Murphy, Saginaw; John M. Murphy, Detroit; Paul H. Muske, Detroit.

John M. Nehra, Detroit.

Charles Patrick, Pontiac; J. P. Pratt, Detroit; Hazen Price, Detroit.

Hugh Robins, Battle Creek; D. L. Rousseau, Detroit.

Jack F. Sanders, Detroit; R. J. Sadowski, Detroit; G. E. Sands, Detroit; Donald Schiff, Detroit; B. W. Schmidt, Detroit; Graham Sellers, Detroit; Milton Shaw, Lansing; Herbert L. Shroyer, Detroit; Robert Simpson, Battle Creek; J. Campbell Smith, Bay City; M. M. Sylvan, Van Dyke.

A. Tauber, Pontiac; Geo. C. Thosteson, Detroit; Franklin H. Top, Detroit.

Henry Van Duine, Grand Rapids.

I. Paul Walker, Grosse Pointe Park; Frank A. Weiser, Detroit; Geo. W. Westcott, Goodrich; Alec Whitley, St. Clair Shores; Stuart Wilson, Detroit; H. C. Wissman, Detroit; Victor Hugo Wolfson, Mt. Clemens.

S. A. Yannhelli, Northville.

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DOCTORS FOR MILITARY SERVICE

The greatest challenge confronting Congress and the medical profession today is "the proper and adequate provision for the care of the great number of horrible civilian casualties that are promised if World War III is to come."

This statement was made by James C. Sargent, M.D., Milwaukee, before the Armed Services Committee of the House of Representatives in expressing opposition to parts of Section 4 of H.R. bill No. 6274. This bill as now worded would authorize the President, pursuant to requisitions submitted by the armed forces, to draft physicians above the age of 25 stipulated as basic in the proposed law.

"To give to the Military Establishment carte blanc as this bill proposes to do, would surely lead to the same over procurement of medical personnel as before," Dr. Sargent said. "And if another war is to come—biologic and atomic warfare this time—large disaster areas with terrible civilian casualties must be expected and must be adequately provided for if the Nation is to survive.

"Ordinary civilian pursuits, agriculture and especially industry—the very foundations of our national war strength—will never survive the high casualties in store for them in another war if civilian doctors are to be thinned down again to the one to 1,500 ratio that was reached during the last war.

"The special provisions in Section 4 (c) and (d) of H.R. 6274 set the pattern for just an unsafe distribution of physicians and set the stage for just such a national catastrophe."

Dr. Sargent is chairman of the American Medical Association's Council on National Emergency Medical Service. With but one exception, eight of the nine members of the Council, including Dr. Sargent, served in the Armed Forces during the recent war. The other member served as one of the five directors of the Procurement and Assignment Service, the agency through which 60,000 civilian physicians were recruited during World War II.

The Armed Services Committee of the House of Representatives were told that a survey made by a special committee of the A.M.A. of some 50,000 doctors revealed:

1. There were far more civilian physicians procured for the armed services during World War II than were effectively needed or used.

2. The subtraction of this large group of physicians from the civilian population left a shortage that was dangerously acute and sorely noticed despite the remarkably healthy state of the nation throughout the war years.

"A national tragedy would surely have occurred had we experienced an influenza epidemic like that following World War I or had we suffered civilian war casualties such as the bombed countries of Europe experienced in World War II," Dr. Sargent said.

The Council chairman added that "if the nation is to survive another war there can be no brooking the waste of medical talent that prevailed in the Army, Navy and Air Force throughout the war just passed." Happily, he said, the Military Establishment, from the Secretary of Defense down, is working toward far better use of the medical personnel and facilities of the three services.

The studied belief of the Council on National Emergency Medical Service and the Board of Trustees of the American Medical Association, stated Dr. Sargent, is that a special provision in the law for the drafting of doctors is "both unnecessary and unwise."

Because of the accelerated program of medical education carried on during the war years, doctors are graduating today well under the age of twenty-six. Through this circumstance, doctors made available under the general draft provisions of H.R. 6274 would be wholly adequate to meet the numerical requirements of Medical officer personnel for the increased strength of the armed forces authorized in the bill."

The point is raised, and properly so, that this would furnish only young, recently graduated physicians. That there is need for some older physicians of special talent is obvious. Such need cannot be great, however, considering the fact that this bill provides for a peace time expansion of the armed forces that does not contemplate heavy casualties of war and, important to note, provides for the medical care of young men in the prime of life and hand picked for their physical fitness.

"There are other ways, less onerous than this proposed legislation, to provide the expert services of experienced physicians and surgeons needed for the expanding Army, Navy and Air Force. The Veterans Administration has pioneered in the use of highly skilled specialists in civilian practice as part-time consultants and the unprecedented excellence of the care that is being given veterans today under such a system merits the serious notice of the Military Establishment.

"Today each city of size in America holds able and thoroughly experienced specialists of every category who are not too deeply rooted to consider rejoining the military as a career were such service made somewhat more attractive. But they recall the barrier that age played against obtaining rank and pay that was commensurate with their exceptional talents. And they recall the withering experience of long periods of inactivity and of non-medical duties."

Doctors, both in and out of service must have clinical medical work to challenge their abilities and keep them professionally alive. While there are certain real inducements to attract able medical talent to a career in military medicine they simply are not enough. Purely administrative changes, dealing with rank and duty assignment, could and would over night minimize the

(Continued on Page 598)

PROTEINS...

Pre- and Post-operative

"Surgical patients in many instances tend to come to operations in a depleted state. There are many reasons for this: chronic gastro-intestinal disease . . . long-standing infectious processes . . . or loss of blood. The preparation of the patient for surgery includes nutritional preparedness. In the first instance, this means a good supply of *proteins* and carbohydrates.

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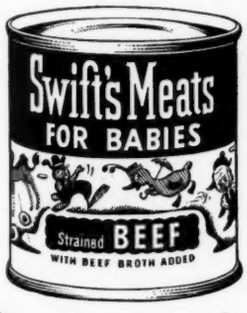

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You and Your Business

WARNING ISSUED ON CONTAMINATED DEXTROSE SOLUTION

A warning to all physicians and hospitals to check their stocks of Cutter's dextrose and saline solution bearing code number CM 8164 was issued today in an editorial which will appear in the May 1 issue of *The Journal of the American Medical Association.*

The editorial states in full:

"On April 19 the Headquarters of the American Medical Association received a wire from Dr. W. F. O'Donnell, Jr., of Hazard, Kentucky, reporting serious reactions in two patients immediately following the intravenous use of five per cent glucose in normal saline manufactured by Cutter Laboratories, Berkeley, California. The American Medical Association immedately notified the Food and Drug Administration of these facts and a nationwide investigation by Federal and State regulatory officials was launched. Not all of the facts are yet available but the following information justifies a warning to all physicians and hospitals.

"At least two and possibly four deaths have occurred in Miami, Florida; Lexington and Louisville, Kentucky, following administration of Cutter's dextrose and saline bearing code number CM-8164. At least eight other serious reactions have been reported, mostly from southern communities. Several hundred one liter bottles with this code number are unaccounted for and the firms shipping records are so incomplete as to make it impossible to trace and recover all of the outstanding material quickly. Although the contaminant has not been identified, it appears to be a heavy growth of bacteria or mold. Many of the unopened bottles show a distinct cloudiness.

"Physicians and hospital officials are urged to check their stock for this code of five per cent dextrose in saline, and if any is found to hold it and notify the nearest office of the Food and Drug Administration which is working at top speed to recover all outstanding material. The Food and Drug Administration requests that none of this product be destroyed in order that an accurate check on the extent of recovery of this dextrose solution can be made.

"This unfortunate incident again emphasizes the necessity for prompt notification of the American Medical Association and the Food and Drug Administration of any suspicious or unexpected reaction following the administration of a drug. Quick action by Dr. O'Donnell in notifying the Association of the reactions in his patients has no doubt saved the lives of many other persons. As yet Cutter Laboratories has offered no explanation of why this contamination was not detected before the product was distributed. The medical profession is entitled to know the facts in this case and to be assured that the drugs they purchase are safe."

CROCODILE TEARS

Oscar R. Ewing, federal security administrator, wound up his stacked seminar to promote the Truman program of state medicine with the announcement that private endowments of medical institutions were drying up and that the federal government therefore would have to subsidize them. About 800 handpicked delegates were invited to Washington for the meeting, but it was disclosed that Ewing had the supposed "report" of the conference half written before they got there.

The security administrator did not choose to examine the reasons why medical schools and hospitals are running into financial trouble. All he needed to do was look back over 15 years of New Deal tax rates to find the reason. Income and estate taxes have been at such confiscatory levels that private donors no longer have the wherewithal to support these and all other kinds of philanthropic institutions.

Ewing's solution is the usual New Deal prescription: The government will fill the gap by siphoning public money into the institutions whose sources of support have been dried up by the same government. In doing so, it will perpetuate if not aggravate the situation over which Ewing weeps by maintaining or increasing the tax rates to produce the new money to go into the institutions.

From the New Deal viewpoints, the scheme works out nicely. Government will further extend its encroachments upon another field of activity which so far has resisted the incursions of the bureaucracy. The cause of socialized medicine will be correspondingly advanced, with the ultimate prospect that the payrollers will take over the whole field of medicine and regiment doctors and the public alike.—Editorial, *Chicago Tribune,* May 9, 1948.

ONE-THIRD OF A NATION

More than one-third of the nation's population has received or is entitled to Federal veterans' or dependency benefits, the Veterans Administration says.

This total includes an all-time high of 18,733,000 living veterans of all wars, plus their dependents and the dependents of deceased veterans.

There are 14,870,000 living World War II veterans.

The VA estimated that by June 30 veterans and their dependents would total 52,300,000, comprising 36.5 per cent of the nation's 143,300,000 population.

By June 30, 1955, this group will reach 60,100,000, or 40.1 per cent of the population, the VA said. From that point on, the figure gradually will decrease.

DOCTORS FOR MILITARY SERVICE

(Continued from Page 596)

medical personnel problems that so concern the armed services today.

"And in the end, if neither of those means are to be employed and experience proves that soldiers and sailors are in need of medical care the profession of America will see they get it, draft or no draft. They did it handsomely in the last war, as, indeed, they always had before. And they would do it again."

Political Medicine

THE NATIONAL ASSEMBLY

The National Health Assembly, called by Federal Security Administrator Oscar Ewing at the request of President Truman, to attempt to work out areas of agreement between the various lay groups and the medical profession for a ten-year health program, ended on May 4 with most groups apparently pleased at the outcome of the intensive four days of serious discussion.

The Section on Medical Care was the most active. It consisted of over one-fourth of the 800 delegates (but listed only eighteen practicing doctors of medicine!). The Resolution of Goals introduced by Nelson Cruikshank of the AFL was referred to the Planning Committee which brought in the following conclusion, preliminary to preparation of its final report:

"1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical, mental and social health should be available to all without regard to race, color, creed, residence or economic status.

"2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test."

"3. Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional

a. services to persons or groups for whom special public responsibility is acknowledged and

b. services not available under prepayment or insurance.

"4. Voluntary prepayment group health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means.

"5. High standards of service, efficient administration and reasonable costs require:

a. Co-ordination of the services of physicians, hospitals and other health agencies in all phases of prevention, diagnosis and treatment.

b. Effective co-operation between the providers and the consumers of such services.

"6. The people have the right to establish voluntary insurance plans on a co-operative basis and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications), now existing in a number of States, should be removed.

"7. A medical care program by itself will not solve the health problems of the Nation. It must be co-ordinated with all efforts directed toward providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation and such other measures as will correct conditions that adversely affect the physical, mental and social health of the people.

"8. There are areas on which the Planning Committee is not yet prepared to report. In the meetings of the Medical Care Section, differing views were expressed as to the method of affectuating the principle of prepayment or insurance. Some believe it can be achieved through voluntary plans. Others believe that a national health insurance plan is necessary."

On the Planning Committee beside Mr. Cruikshank were Chairman Hugh Leavell, M.D., of Harvard, Ernst P. Boas, M.D., of the Physicians Forum, Thomas A. McGoldrick, M.D., Brooklyn, and James R. McVay, M.D., Kansas City, members of the AMA Council on Medical Service, C. Rufus Rorem, M.D., of the Philadelphia Hospital Council, Louis Wright, M.D., New York, and Messrs. Horace R. Hansen of the National Co-operative Health Federation and Harry Read of the CIO.

* * *

MEDICAL CARE FOR THE INDIVIDUAL

Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare requested the Brookings Institution to make a survey for the use of his committee in considering National Health Legislation. The full report will be published at a later date but the conclusions are as follows:

Conclusions

The conclusions based on this foundation are:

1. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogenous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.

2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care.

3. The nonwhites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.

4. The advances in health among both the whites and the nonwhites have been made in the United States in the past four decades do not suggest basic defects in the American system.

5. Although the statistics resulting from the administration of the Selective Service Act—the so-called draft statistics—have been widely used to show bad health among the American people and the need for revolutionary changes in arrangements for medical care of individuals, they are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole.

6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the Second World War.

7. The conditions in extremely poor rural areas that lack the resources to support adequate public services, such as health work, education, and highways cannot be satisfactorily solved by subsidies. This problem calls for a radically different approach, either bringing in new or

(Continued on Page 602)

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MEDICAL CARE FOR THE INDIVIDUAL

(Continued from Page 600)

improved economic activities or getting the people to more favorable and administratively less expensive areas. This condition has been accentuated by the emigration of youth from these areas to urban communities.

8. The United States has some individuals and families not possessed of the resources to enable them to pay for adeqquate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements.

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

12. The administration of compulsory insurance would require thousands of Government employes for accounting, auditing, and inspection and investigation.

13. The cost of medical care presumably would increase because of (a) administrative expenses; (b) the tendency to insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (c) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.

14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.

15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (a) fee for service, (b) per capita, or (c) salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

Recommendations

1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent co-operation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Government administration. It seems highly improbable that this experimentation—possible under our Federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtless then be adopted with a great degree of unanimity. If compulsory insurance should be adopted now by a narrow vote in the Congress, thousands of persons who are opposed to it would start hostile to the whole undertaking.

2. For the time being the National Government and many of the State governments may well devote their resources and energies to:

(a) Research and developments in the fields of public health;

(b) Health education at the school level;

(c) Teaching of preventive medicine;

(d) Assisting in the acquisition of physical facilities and training of personnel;

(e) Providing systematic care for the indigent and the medically indigent. In some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and co-ordinated program.

3. From the standpoint of public relations, governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, State, and local voluntary organizations which have been able to enlist the active co-operation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are nonmedical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest, and co-operation of individuals, families, and local communities.

These recommendations are not widely at variance with those of the majority of the Committee on the Costs of Medical Care, arrived at in 1932 after a comprehensive study. The report of the committee says:

> * * * [The] majority of the committee does not endorse the recommendation which would make health insurance a legal requirement for certain sections of the population. These members realize that such a step may ultimately be necessary and desirable in some States, but they believe that for most States and probably for almost all of them at the present time, it is much more desirable (a) to encourage voluntary measures for protection against wage loss during sickness, and (b) to develop voluntary insurance for medical care in conjunction with group practice, with hospital service, and with the related measures recommended on the preceding pages. They are of the opinion that the difficulties of these plans can be controlled by a combination of professional and community effort, and that these plans hold the promise of steady extension in scope of service and in proportion of the population served. These members believe that the various payment plans (aside from compulsory insurance) if fully carried out, would: (1) largely solve the problem of hospital costs which constitute about 50 per cent of the average family expenditure for the care of sickness; (2) provide adequately for many rural areas in which serious deficiencies of facilities exist at present; (3) make more nearly adequate provision that exists at present for the "indigent" and for the care of certain diseases of public importance; and (4) provide, through voluntary co-operative insurance * * * medical service to a majority of the 70,000,000 people living in industrial communities and in cities.[3]

[3]Medical Care for the American People, the final report of the Commitee on the Costs of Medical Care, Oct. 31, 1932, p. 130.

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Editorial Opinion

OFT IN THE STILLY NIGHT

The public, according to complaints received by the American Medical Association, believes that it is not getting the service it requires from its doctors. A particular grievance is the difficulty—on occasions the impossibility—of obtaining emergency medical service at night.

For various reasons a reactionary attitude toward self-sacrifice has set in since the war. The devotion to a common cause in those soul-trying years elevated many persons to a heroic state of mind. Now, at least in this country, "We the people" are demanding the pay-off. We want things material, and we want them now.

The medical profession must bear its share of this failure to see eye to eye and clearly. In too many phases of its work there has been an increasing divergence from the public interest rather than an improved cordialty in public relations. The trend toward socialization has been a trend also toward the impersonalization of medical service.

During the war, 60 per cent of the nation's physicians —and they comprised the older group—remained at home, assuming their absent colleagues' duties. They were, on the whole, overworked, but, on the whole, as old-timers they accepted the responsibilities that appeared to them to be part of the obligations of a career of service. Many of them now believe that others should bear the extra burden, and this is what the others seem unwilling to undertake. The youngsters seem to have failed to acquire the idea that they have accepted a calling.

If an obligation implicit in the practice of medicine now fails of spontaneous fulfillment, however, some organized measures must be taken to provide what is lacking. The American Medical Association suggests that county medical societies or urban groups maintain telephone exchanges that will accept the responsibility for locating physicians available for emergency calls.

The majority of the older practitioners have led lives so organized that they were never, year after year, "off call" without a substitute constantly available. It is one of the responsibilities that those who care for the sick have accepted and must continue to accept: Those for whom they care must never be abandoned.—Editorial, *The New England Journal of Medicine*, May 6, 1948.

THE JOB OF THE COUNTY MEDICAL SOCIETY

"The County Medical Society in many areas has become just another society." This statement by Dr. Louis Bauer, (AMA Trustee and President of the Medical Society of the State of New York) is an alarming truth. Medicine has become over-organized. Surgical societies, obstetrical societies, pediatric societies, general practice societies, and others have sprung up everywhere. In many places this movement has reduced the interest in county society activities, has lowered attendance at society meetings, and has diminished the influence of the county medical society in the community.

Today the influence of the county medical society is needed more than ever before. The individual physician must be kept united and informed; the public must be educated as to the problems of medicine, both scientific and economic; and liaison must be maintained with lay groups and organizations in the community. These are functions of the county medical society.

What are the responsibilities of a county medical society? The county medical society has a responsibility to the public, a responsibiilty to its membership, and a responsibility to medical organization. There is no order of preference; all are equally important. One cannot survive without the other two.

The first step toward understanding within the membership is to succeed in an understanding among the county medical society officers.

The Third National Conference of County Medical Society Officers, scheduled for June, is designed to assist in this step as well as to arrive at a measure of agreement in regard to the meaning and extent of such responsibilities. Every county medical society has been issued an invitation to send its officers to the Conference. Each officer attending will be free to enter into the discussion and to express his thoughts and ideas on THE JOB OF THE COUNTY MEDICAL SOCIETY.

The thoughts and ideas expressed will be correlated and forwarded to the president or secretary of each county society and from there on it will be up to them, and to every committee member, and to every society member, to give attention to the problem.

The county medical society is as effective or as ineffective as its success in carrying on its responsibilities. Such success depends on the individual physicians who make up each society.

THE STRENGTH OF A CHAIN IS THE STRENGTH OF ITS WEAKEST LINK. DON'T HAVE ANY WEAK LINKS IN YOUR SOCIETY.—Editorial, Kent County Medical Society *Bulletin*, May, 1948.

SHOULD BUREAUCRATS PRACTICE MEDICINE?

A good deal of what is happening in Britain under a labor government is of pressing interest to Americans, because some of the rough going encountered by social theorists looks like a preview of what can happen in this country under similar legislation.

To take one very important example, the Socialist majority in Parliament passed the National Health Service Act. Its provisions, to go into effect on July 5, 1948, were designated to unify medical and auxiliary services in an insurance scheme directed by the state and supported by compulsory contributions from all citizens. However, physicians were to be free to join or not to

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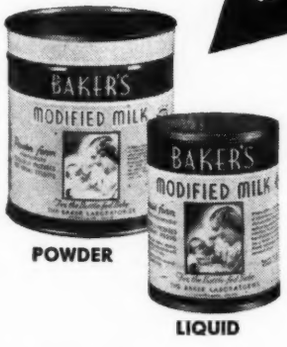

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BAKER'S MODIFIED MILK

Should Bureaucrats Practice Medicine

(Continued from Page 604)

join the contemplated service, as they pleased. This preserved a principle of freedom, at least in appearance. The British Medical Association opposed passage of the law, but the Minister of Health and his advisers felt confident that they had written in enough guarantees of economic security to attract rank-and-file doctors.

In February, almost five months before the act will take effect, the BMA—comparable to the AMA in this country—took a plebiscite of all doctors on the register. The Minister of Health intimated that the plebiscite would be framed, and that the BMA was a fogbound organization of Tory reactionaries. Beatrice and Sidney Webb, the father and mother of the British Labor Party, once described the BMA as a most enlightened and responsible professional body. That made no difference. It was now in the way, and had to be smeared.

The result of the poll ended all talk of sinster pressure. Eighty-two out of every hundred physicians eligible to vote filled out their ballots and signed their names. Nearly 90 per cent said they disapproved of the plan, and would not join it.

For eager social engineers, the figures were baffling. No matter how they were broken down, examined and analyzed, it was plain that a nonpolitical group, many of whom must have voted Labor in the last general election, had returned an immense majority against the government. As The Economist pointed out: "Youth and crabbed age, serviceman and civilian, salaried and nonsalaried, public and private practitioner, specialist and general practitioner—all have decided, by a large majority, to put professional solidarity first."

In the practice of medicine, professional solidarity is not only economic in character, it is also at the root of ethical standards and of the doctor's freedom. If the BMA stands almost 9 to 1 against the scheme, they must have more than pocketbook reasons, in view of the attractive terms offered in the act.

One explanation of their stubborn resistance to Utopia might be found in the notorious waste of medical and surgical skills by the armed services, abroad as well as here, during the war. In a rigid framework of state authority, whether political or military, earnest and able doctors frequently find themselves blocked off in idle corners or working under superiors in rank only.

Moreover, the old adage about paying the piper and calling the tune still holds. In this country, for example, a specialist treating a tuberculous veteran receives his fee from the Veterans Administration. But he may not use streptomycin in the treatment, except in the amounts and at the intervals and under the conditions prescribed by the VA. Some very eminent experts disagree completely with the official method, and describe its enforcement as little more than using veterans as guinea pigs. That makes no difference when Authority has spoken.

Points like these, which are really capital points, not only from the physician's point of view but from the patient's, are brushed aside by British and American planners. After the plebiscite of the BMA, the Minister of Health talked darkly of "sabotaging an act of Parliament"—surely a strange expression to use about professional men who announced a choice which the law explicitly allows them.

In the United States, advocates of the National Health Insurance and Public Health Bill, commonly called the Wagner-Murray-Dingell Bill, take the same high line. They describe the Taft Bill as only a "sop," because it limits Federal assistance to places where it is needed and to persons who have no other resources. The AMA opposes the grand design of national health insurance, with its 3 per cent payroll deductions, its cumbersome controls and all the rest of the familiar features of bureaucratic legislation. The doctors, with the exception of a small independent committee, have endorsed the Taft Bill.

Before this country gets into anything like the British medical stalemate, it might be a good idea to consider whether the large majority of people practicing a profession are not the best judges of how to extend and improve their service.—Editorial by Paul Jones, *Saturday Evening Post,* May 1, 1948.

INTERPRETATION

Hospital residents have been ruled educational trainees by the administration. This makes veteran residents in civilian hospitals eligible for increased subsistence allowances under the recently-passed Public Law 411. Interns are classed as on-the-job trainees, and still are not eligible for the raise.—*Hospitals,* May, 1948.

MEDICAL CARE FOR THE INDIVIDUAL

(Continued from Page 602)

The years since 1932 have witnessed—

1. A great growth in voluntary insurance both for hospitalization and for medical services.

2. State experimentation with compulsory health insurance in Rhode Island and California.

3. A growing willingness on the part of practitioners to co-operate in the development of prepayment plans and other devices to enable patients who so desire to regularize their payments for medical care.

4. A profound change in the amount and distribution of the earnings of the American people. This change greatly reduces the number who cannot afford adequate medical care if they desire to purchase it.

The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the majority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress.

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The Cornelian Corner

Practical Application of Basic Mental Hygiene Principles

By Leo H. Bartemeier, M.D.

Detroit, Michigan

SOME TIME during the early months of 1942, two Detroit physicians, a pediatrician and a psychiatrist, who regularly met each other for luncheon, began to engage in serious discussions about a problem which had been concerning each of them for a rather long time. The pediatrician was preoccupied with the difficulties which so many mothers experienced in connection with the feeding and the care of their infants. It seemed to him that much of their anxiety and the obvious dissatisfactions of their infants were unnecessary and unnatural. In his effort to solve this problem he had broken with the traditional procedures and had advised the mothers to feed their infants as often as they seemed to want nourishment and to let them have as much as they would take. The results had been most gratifying. The mothers' anxieties diminished and the infants were appreciably more contented. This departure from the rigidity of feeding schedules was contrary, however, to what he had been taught and not in keeping with the practice of his colleagues. The psychiatrist with whom he discussed this matter had been particularly concerned about the difficulties he had experienced in treating patients who suffered from severe mental disorders which often required long periods of hospitalization. He knew that their illnesses stemmed from intense dissatisfactions they had repeatedly suffered in their infancy and babyhood. He was intrigued with the contentment and satisfaction of both mothers and infants which the pediatrician had observed after he had allowed the infants to indicate how much and how often they should receive nourishment. In this radical break with traditional pediatric procedure, the psychiatrist saw one possibility for improving the mother-child relationship and for lessening the incidence of the serious mental disorders of adult life. Like the pediatrician he was especially interested in preventive medicine.

These two physicians then began discussing their mutual interests with a few of their colleagues, and they learned that they too were concerned with the same problems. This small group, which included an obstetrician, an expert on nutrition, a registered nurse and a clinical psychologist, decided to continue and enlarge the original discussions between the psychiatrist and the pediatrician and to meet at regular intervals for the purpose of this collaboration. Accordingly, on November 12, 1942, they formed a small organization which they named the Cornelian Corner. The first article of the constitution which they framed at that time describes why they chose this name for their society. It reads as follows:

"This association shall be named after Cornelia, daughter of Scipio Africanus, the Elder, mother of the Gracchi and of Sempronia, the wife of Scipio Africanus, the Younger. On the death of her husband, refusing numerous offers of marriage, she devoted herself to the education of her twelve children. When asked to show her jewels, she presented her sons, and on her death a statue was erected to her memory inscribed, 'Cornelia, the mother of the Gracchi.' The sons, Tiberius and Gaius, devoted their lives to the welfare of their fellow men.

"When the kitchen was used by the family as a 'living room' it was customary for the mother to face a corner of the room when nursing her infant. Thus her back was turned to others in the room, and both she and the infant were more removed from disturbing influences."

During the early meetings of this small group their discussions were confined in the main to the cultural influences which have effected a near disappearance of the nursing of infants, and how this natural procedure might be re-established in the American scene. As their discussions continued, their objectives came to include all those early parental influences which determine so importantly the favorable or unfavorable evolution and development of character traits. They outlined these objectives in Article II of their constitution, which reads as follows:

"*Purpose*—Believing that a program aimed at relief of the cultural tensions so frequently incident to feeding, toilet training, and child discipline, represents the nuclear approach to the problem of mental hygiene, we dedicate ourselves to such a program.

"The purpose of this association, therefore, shall be to promote healthy parent-child relationships.

"We will strive toward the achievement of this objective:

1. Through research in the fields of child development and family life.
2. Through the education of parents, especially expectant mothers and fathers, as to the basic needs of the developing child.
3. Through the wide promulgation to professional groups of all pertinent information regarding the developing child and his environmental needs.

(a) We will strongly advocate the abandonment of the artificial practice of separating the newborn child from his parents.

(b) With the conviction that it is advantageous to both mother and child, we will encourage the breast feeding of infants with opportunity to nurse whenever the infant is hungry or anxious."

During the five years that it has been in existence, the Cornelian Corner has won the interest and the enthusiastic support of a surprisingly large number of people. For the past two years it has conducted seminars for physicians and for the nurses in charge of the pediatric and obstetrical wards in the general hospitals of metropolitan Detroit and the neighboring communities. These seminars have been made possible through a grant from the Children's Fund of Michigan. They have been conducted by leading pediatricians, psychiatrists, obstetricians and other specialists in the field of child development. In addition to this educational project, the Cornelian Corner has gained the co-operation of five Detroit hospitals in its project to have infants remain in the same room with their mothers from the time of their birth. This has already been carried out in a number of instances, and some valuable data have been collected which already demonstrate the desirability for such procedures.

This brief history of the Cornelian Corner of Detroit constitutes a new development in preventive medicine and represents the first organized reaction to the most crucial human problem in our culture. This problem is reflected in the objectives of the Cornelian Corner. These objectives aim to re-establish the practices in infant care which were in vogue fifty years ago, when babies were born in the home and mothers and fathers sensed the importance of satisfying their needs. Fifty years ago it was customary for mothers to nurse their babies, to feed them as often as they seemed to need nourishment, and to give them a great deal of mothering. Fathers commonly assisted in the care of their infants, and brothers and sisters had free access to the new baby almost from the time of its birth. These practices were wholesome and natural, but many mothers died in connection with childbirth, and the percentage of infants who succumbed to infections was very large. It is a tribute to the progress of medical science that the number of maternal and infant deaths has been reduced to a minimum. The scientific discoveries which have protected the lives of so many mothers and infants have eliminated, however, many of the old-fashioned practices connected with infant care. Physicians have concerned themselves with the strict enforcement of all procedures which insured the saving of human life. The personal care that mothers and fathers had previously bestowed on their newborn became the professional duty of hospital nurses, and the isolation of the infant became an accepted procedure. Strict medical rules and regulations for the feeding and general care of the baby in the home replaced the natural ways in which parents of a former generation looked after their offspring.

The Cornelian Corner encourages the restoration of these folkways within the framework of present-day medical procedures. The rationale for this new effort lies in the fact that the great discoveries of Freud have revealed that the old-fashioned practices were psychologically sound and essential for the wholesome evolution and development of personality. These discoveries, which were derived from years of painstaking clinical investigations, have not only been confirmed by the researches of many other psychoanalysts but

have gained general acceptance by psychiatrists and an increasing number of pediatricians. These discoveries reveal why the separation of infants from their mothers and fathers in our modern hospitals is unhealthy for both the parents and their offspring, and why it prepares for difficulties in the subsequent parent-child relationship. These clinical investigations have repeatedly demonstrated that throughout the period of infancy and babyhood the entire existence of every child is dominated by two inherited strivings. One of these is the instinct of hunger, and the other is the instinct for love and all that it implies at this period of development. Experiences which interfere with the gratification of either one of these instinctual strivings produce tension, discomfort and pain. The repeated occurrence of such states of tension gives rise to anxiety, to disturbances in digestion and to other interferences with the natural development of the child. Every infant, for example, in addition to the satisfaction of his hunger, also needs the gratification of his impulse to suck. No man-made schedules can adequately supply the satisfactions of these instinctual needs. They are inherited biological strivings which every good mother senses and knows how to satisfy. They vary in their intensity from one child to another—just as each infant even in the same family shows individual characteristics from the time of its birth. The need for a great deal of close proximity to his mother's body and all that we understand by the term mothering is just as important for the wholesome development of the infant as the need to be adequately fed. This natural mothering establishes the first human relationship which becomes the foundation for all other subsequent relationships and influences the character of the individual throughout his entire life. These facts demonstrate the necessity for the natural mothering process from the time of birth and throughout the period of infancy and babyhood. In brief, we now possess a body of scientific knowledge regarding the optimum care of the child which demonstrates that the parents of a former time sensed the instinctual needs of their infants and the necessity to satisfy them for the sake of their well-being.

The second objective of the Cornelian Corner is "the education of parents, especially expectant mothers and fathers, as to the basic needs of the developing child." The Cornelian Corner encour-

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Allergic Dermatoses

Recognition and Management

By Sidney Friedlaender, M.D.
Detroit, Michigan

ALLERGIC REACTIONS involving the skin constitute a great percentage of the skin eruptions commonly encountered in daily practice. It is essential to recognize the allergic nature of these conditions in order that proper treatment may be carried out. The determination of specific sensitizing factors is the keystone in the successful management of allergic dermatoses. These specific elements may be fairly obvious in some cases, while a careful and diligent search may be necessary to uncover them in others. A thorough history is an extremely important aid in properly classifying allergic skin reactions, and in addition will often reveal important points of etiologic significance. Laboratory aids, such as cutaneous, intradermal, and patch tests, give valuable information if properly performed and intelligently interpreted.

Considerable morphologic difference exists in the various allergic syndromes of the skin, but all have in common a specific sensitization mechanism. The most frequently encountered dermatoses in which allergy is agreed to play a dominant role are atopic dermatitis, contact dermatitis, urticarial eruptions, "id" reactions, and drug eruptions. While the lesions in these syndromes are not always typical, they assume for the most part a characteristic configuration and distribution, which aid in their classification and diagnosis. The important points in the recognition, etiology and management of these conditions will be considered in the ensuing discussion.

Atopic Dermatitis

This widely encountered allergic skin disease is frequently designated in the literature under such terms as eczema and flexural eczema. Some cases referred to as disseminated neurodermatitis and lichen simplex chronicus disseminatus may also belong in this group. Atopic dermatitis can occur

in infancy, chilhood or adult life. Cases which begin early may disappear before the age of puberty, while others frequently continue into adulthood. Ofttimes the dermatitis begins in late childhood or young adult life without a preceding history of the infantile type. An initial onset of the disease in older adults is not rare. For purposes of discussion, however, it may be well to consider the earlier type, infantile eczema, apart from the atopic dermatitis of childhood and adult life. All are essentially the same disease, the disturbance involving the superficial layers of the cutis. The allergen responsible, usually protein in nature, is absorbed from the respiratory or gastrointestinal mucosa and reaches the superficial blood vessels of the cutis by the hematogenous or lymphogenous route. Immediate whealing reactions to specific allergens are obtained on cutaneous or intradermal testing in this group of patients. The proper interpretation of these reactions is of great value in planning specific therapy.

Infantile eczema usually begins in the first two or three months of life, involving the face and later spreading to the extremities and trunk. It is associated with considerable pruritis, and the resultant scratching frequently results in a secondary infection. The lesions are pleomorphic, often characterized by vesicle formation, oozing and crusting. As the disease progresses, a flexural distribution becomes more evident. In some cases the eruption disappears spontaneously by the end of the second year, only to be replaced by other allergic manifestations such as rhinitis or asthma. In other cases the disease may continue and assume the characteristics of the atopic dermatitis of older children and adults. A high incidence of familial allergy is present in these infants, attesting to the atopic nature of the condition. As already mentioned, the skin disorder is frequently the first of a series of allergic manifestations scheduled to occur in that individual. Control of the cutaneous allergy early in life may go far in influencing the course of later and more serious disturbances of the respiratory tract.

Food is the most commonly recognized cause of atopic dermatitis of infancy, either reaching the child through the mother's milk, or by direct ingestion in the case of the artificially fed infant. Among the foods often causing difficulty are cow's milk, wheat, eggs, citrus fruits, fish oils, and meats. In recent years it has become more widely recognized that environmental allergens play an extremely important role in these infants, and that measures for their control should be instituted early.

The atopic dermatitis of children and adults assumes a greater flexural distribution, although generalized involvement of the face, neck, trunk and extremities is frequently observed. Erythema, papulation, vesiculation, with later lichenification, is the characteristic picture in this group. Pruritis is a prominent feature and during exacerbations, the rupture of vesicles by scratching results in oozing, crusting, and secondarily infected lesions. In children a spontaneous involution may occur around the age of puberty. In others the disease extends into adult life. The condition is by no means limited to young adults, and is observed in individuals past forty. In some instances it may even orginiate after the age of fifty without any preceding history of eczema or other allergic disease.

Associated allergies of the respiratory tract are commonly present in these patients, and often intense enough to relegate the cutaneous allergy to a secondary place in the over-all allergic management. Food allergens, while important in many instances, play a less significant role than in the infantile type. Inhalants, such as house dust, pollen, molds, feathers and animal danders, assume a greater importance in these cases. Sensitivity is frequently extreme, and the small amounts of antigen used for hyposensitization may be sufficient to flare up the skin lesions.

While specific sensitization is the prime etiologic element in atopic dermatitis, nonallergic factors may also have some influence. Emotional stimuli, endocrine imbalance, and atmospheric changes are among the non-specific factors that may exert some effect in these individuals. Not infrequently, observers are prone to attribute primary etiologic importance to these nonspecific factors, because of their association with exacerbation of skin lesions. These influences play no more than a secondary role, and frequently are the trigger mechanisms which upset the allergic balance and initiate symptoms.

Contact Dermatitis

This type of allergic response, which includes the industrial dermatoses, constitutes a large proportion of all dermatologic lesions. It is essentially a disease of the superficial skin layers resulting from direct contact of the allergen with the epi-

dermis. Lipoids, oil soluble substances, metals, simple chemicals, and dyes are frequently the cause, in contrast to the protein allergens which are the offenders in many other types of allergic reactions. The dermatitis in these cases is dependent to some extent on the potency of the sensitizing agent, the length of exposure, and the resistance of the skin. Thus, industrial workers may develop a contact dermatitis from a potent sensitizer after relatively short exposure, while a less active agent may require a longer period to produce an eruption. Skin whose resistance has been lowered by contact with strong acids or alkalis, or by the presence of other skin disease, may be more readily sensitized than skin whose normal protective barriers are intact. In any case, the skin must be initially sensitized before subsequent exposure will result in an eczematous response.

The primary lesion of contact dermatitis is the vesicle, which may appear from several hours to several days after exposure to the contactant. Initially the lesions are localized to the area of contact, but may later become generalized. Frequently they are limited to the exposed parts of the skin not covered by protective clothing. In other instances the eyelids or neck may first be involved, despite earlier contact with other parts of the skin.

The most notable example of contact dermatitis is that produced by poison ivy and related plants. The lipoid antigen of poison ivy is capable of readily sensitizing the majority of individuals. The oily fraction of the ragweed group of plants are also frequent sensitizers during the summer months. Various materials in industry are responsible for cases of contact dermatitis. Among the most common are dyes, coal tar products, paints, lacquers, solvents, resins and waxes. The dyes and finishes in various articles of clothing are frequently incriminated in nonindustrial cases. Cosmetics constitute a great source of difficulty in women. The frequency of nail polish dermatitis is now commonly recognized, and eruptions from soaps, lipstick, hair lacquer, leg make-up, deodorants, and hair dyes are frequently seen. Metals such as nickel, mercury, chrome and their salts, which are almost universally encountered, are frequently responsible for dermatitis. The use of local anesthetics, mercurials, sulfonamides, penicillin, and many other common drugs in the form of ointments or solutions used for skin therapy will frequently produce a contact dermatitis superimposed on the primary skin condition under treatment.

Specific diagnosis of contact dermatitis is carried out by means of the patch test. The primary irritant properties of the test substance must first be ascertained in order that a proper interpretation may be made. It must be prepared in a form which will not produce an irritating reaction in a nonsensitive individual on prolonged contact. The test materials are applied to the skin and covered by a patch, a reading being made at the end of twenty-four to forty-eight hours. Any resultant positive reaction is a duplication of the contact lesion.

Urticaria and Angioneurotic Edema

These two conditions are essentially the same disease, modified by the structures they involve. The primary lesions is the wheal, which is considered by many to be the basic unit of the allergic reaction. Urticaria signifies the small discrete lesions involving the superficial layers of the cutis accompanied by intense itching, while angioneurotic edema consists of localized edematous swellings involving the subcutaneous tissues and other deeper structures. These larger swellings are prone to occur in the tissues of the lips, eyelids, tongue, hands and feet while the smaller urticarial lesions more frequently occur on the trunk, arms, and thighs. Cutaneous and intradermal testing may give important information in this group of cases. While the clinical correlation between positive skin reactions and symptoms is not as frequent in this group as in other forms of allergy, the tests occasionally give important diagnostic information which justifies their performance in difficult cases.

Considerable difference of opinion exists regarding the etiology of urticaria. While it is difficult to prove conclusively an allergic basis in each case, this type of approach offers the best possibility of an ultimate solution of the more vexing cases. A fair percentage of patients with urticaria give a familial history of allergy, and in many instances have other syndromes of an atopic nature. Gastrointestinal dysfunction, focal infection, endocrine imbalance, and psychic factors have been accused of primary importance in chronic cases. These undoubtedly play a part in certain instances, but it seems more likely that they are not the primary cause, but act as secondary or aggravating factors.

Acute and chronic types of urticarial eruptions

are recognized. Fresh fruits and vegetables, seafood, and nuts are often etiologic factors in acute cases. Staple foods such as wheat, milk, egg, corn, and white potato are more likely to be responsible for chronic cases. Drugs very often produce severe urticaria. Aspirin, barbiturates, and penicillin are among the most frequent offenders. The wide use of penicillin recently has resulted in an increasing number of severe "serum sickness type" of urticarial reactions which may persist for many days after the medication has been discontinued. Injectable substances, such as liver, insulin, and therapeutic serums, may also cause urticarial reactions. Environmental allergens, such as pollen, animal danders, cottonseed and flaxseed, may produce urticaria in sensitive individual upon inhalation. Urticaria from physical agents, such as heat, light, and cold is not uncommon.

"Id" Reactions

"Id" reactions represent an acute allergic response of an inflammatory nature to the metabolic products of fungi. Localized fungus infections of the skin are capable of sensitizing the entire skin to their products of growth. This sensitization is similar in nature to that produced in tuberculosis, and is demonstrated by the delayed inflammatory reaction elicited by the intradermal injection of the fungus extract in sensitive individuals.

The allergic responses which frequently occur spontaneously in those suffering from fungus infections of the skin are termed trichophytids, epidermophytids, monilids, or microsporids, depending on the causative infecting agents. Fungi cannot be recovered from these lesions, since they do not represent a spread of the infection. The feet are the most common site of primary fungus infections, while the hands are most frequently the site of the "id" reaction. The secondary lesions on the hands are usually vesicular in nature, occurring singly or in groups, and are accompanied by intense pruritis, often breaking down to form a fissured and eczematized dermatitis. "Id" reactions are not always limited to the hands, and may at times be generalized and papular or lichenoid in nature. They may often be confused with other dermatologic conditions, and diagnosis should be based on the appearance of the lesions cofection elsewhere. Inasmuch as primary fungus existant with the presence of an active fungus ininfections of the skin are so prevalent, the "tuberculin-type" reaction obtained from fungus extracts may be obtained in the majority of individuals and be of little help in making the diagnosis of "id" reaction. A negative response would be of more significance in ruling out these lesions. Occasionally an immediate whealing reaction is obtained on testing with fungi, and may be of greater significance in diagnosis than the delayed type.

Drug Eruptions

Skin eruptions following the use of drugs (dermatitis medicamentosa) are commonly encountered and must always be considered in the presence of a dermatitis of doubtful etiology. Such common drugs as aspirin, antipyrine, bromides, iodides, opiates, mercurials, arsenicals, quinine, phenophthalein barbiturates, sulfonamides and penicillin, may produce dermatoses. Despite clinical evidence of sensitization, as demonstrated by the recurrence of the eruption following the use of the drug, skin tests with drugs are usually negative. There is considerable experimental evidence however that drugs, which are compounds of low molecular weight as compared to protein antigens, combine with body protein to form an antigenic complex responsible for sensitization.

Urticaria is the most common form of skin eruption following the use of drugs, and has already been discussed. Morbilliform rashes, acneiform lesions, purpura, bullae, fixed eruptions, erythema nodosum and multiforme type lesions are frequently the result of drug sensitivity.

Treatment

The most satisfactory results in the management of allergic dermatoses are obtained by a judicious combination of specific and nonspecific treatment. Local dermatologic therapy and other nonspecific measures designed to control inflammation, pruritis, and secondary infection, are helpful in restoring the skin to its normal state. A great deal cannot be expected from such treatment in most cases, unless the specific allergens responsible are determined and controlled.

Nonspecific Treatment.—Local therapy employed in the acute phases of allergic dermatoses is in no way different from that used in other types of acute dermatitis. Wet dressings of Burow's solution, boric acid, or potassium permanganate are helpful in controlling the acute inflammatory

reaction of the skin. In the subacute and chronic phases, lotions and ointments may be employed. Such therapy must always be used with care because of the possibility of aggravating the skin condition. In the subacute phase, lotions such as calamine with or without phenol may be helpful. Bland ointments containing boric acid or liquor aluminum acetate in aquaphor or lanolin are frequently desirable. In the more chronic stages, tar in the form of liquor carbonis detergens, or crude coal tar, combined at times with a small percentage of salicylic acid, may be applied in ointment form. The antihistaminic agents used orally, parenterally, or topically, are at times helpful in diminishing pruritus. In the urticarial dermatoses they are frequently successful in controlling the lesions. Fifty to 100 mg. four times daily is usually sufficient to keep the patient comfortable. In extreme cases 10 to 50 mg. of benadryl intravenously may be helpful in producing sedation and controlling symptoms otherwise resistant to symptomatic measures.

In the treatment of "id" reactions, it is essential to locate and control the primary focus of infection. Treatment of the infected area with fungicidal agents will frequently result in the disappearance of the secondary "id."

Specific Therapy.—The treatment of specific allergic factors is of course dependent on their recognition. While skin tests are helpful in making an etiologic diagnosis, too much dependence is often placed on this laboratory procedure. Without a careful history, physical examination, and an understanding of the applicability and limitations of skin tests in the case under study, they frequently are of little help, and in many instances totally misleading. Properly employed and interpreted, they are an extremely valuable aid in diagnosis. Specific therapy in the allergic dermatoses is based on the elimination of the offending allergen wherever possible. When this cannot be accomplished, desensitization is indicated. The control of specific allergens can be conveniently discussed under the headings of ingestants, inhalants, and contactants.

Ingestants.—Where food or drugs are the cause of allergic symptoms, the most satisfactory treatment is obtained by complete elimination. The determination of the offending ingestant entails study beyond history taking and skin testing. Trial diets and the use of the food diary are frequently necessary to confirm the diagnosis. Rarely it may be necessary to consider desensitization. This may be attempted in the case of such basic foods as wheat, milk, or eggs. In such instances, the oral route is employed. Doses of the specific food below the symptom-producing level are given orally in gradually increasing amounts until the patient is able to tolerate the food normally. Adequate desensitization by this procedure may be difficult, and is often impossible to attain. Hypodermic desensitization to foods is not satisfactory, and frequently is dangerous.

Various approaches may be used in dietary investigation. A preliminary diet, based on the elimination of positive skin reacting foods, is frequently tried. The Rowe type diets, employing a relatively small number of foods of low antigenicity, are often used as a starting point. The elimination of certain foods from the diet on basis of their frequent association with the type of condition at hand may be adaptable to some cases. The use of a single basic food for a period of time, to which additions are gradually made, is sometimes applicable, but in most instances is very difficult for the patient to follow. Some time ago we experimented with the use of synthetic diets containing amigen, dextrose, mineral salts and vitamins as a starting point in the diagnosis of food allergy. The unpalatability of the mixture limited the use of this otherwise ideal approach. A week to ten-day period is necessary before the effect of a basic diet may be assessed. If symptoms have abated by that time, additions of single foods may be made at four- to five-day intervals, and flareups noted in relation to their introduction. A food diary is essential for a proper record, and may be helpful in determining any delayed reactions which can occur several days after the food has been introduced.

Inhalants.—History will often give a clue to the role of inhalants in skin allergy. The incidence of the eruption at certain seasons of the year, its aggravation in certain environments, and its improvements in relationship to change of climate or occupation, may frequently be noted. The correlation between positive cutaneous and intradermal skin reactions and clinical symptoms is often greater with inhalants than in the case of ingestants. Where a pet, an item of furniture, an article of clothing, or a cosmetic, is responsible for symptoms, the procedure of choice is to eliminate the offender

from the patient's environment. Inhalants such as dust, pollens and fungi, however, cannot be controlled by such simple measures, and it is necessary to employ desensitization when they are the responsible allergens. The method employed is similar to that instituted in other allergies such as rhinitis, asthma, and hay fever. It is usually necessary, however, to begin with much smaller doses of the specific antigen than used in respiratory allergies, because of the extreme sensitivity present in these patients. Exacerbations of skin lesions are prone to occur following injections, unless the patient's tolerance is correctly gauged.

Contactants.—The only completely satisfactory treatment of contact dermatitis is the elimination of the offending allergen. Desensitization therapy to most of the agents producing contact dermatitis, with the exception of the plant oils, is of little avail. Satisfactory desensitization is frequently possible in the case of the lipoid fractions of the poison ivy group and ragweed family. As previously mentioned in the discussion of contact dermatitis, patch testing is the investigative tool employed in specific diagnosis. The selection of materials for testing is dependent on the patient's environmental contacts. Care must be taken in their selection and preparation for testing. The use of skin as close as possible to the area of dermatitis should be employed. Positive reactions and their relationship to the dermatitis must be carefully evaluated. A positive test reaction to a certain substance does not necessarily incriminate that item as the cause of the current difficulty, since the skin may become sensitized to many substances after initial contact. Frequently it is necessary to differentiate a contact dermatitis from some other form of eruption. Testing with a group of common contact allergens may be helpful in classifying the condition. The occurrence of one or more positive reactors may indicate that the case is one of contact allergy, and further investigation of likely contactants indicated.

Summary

The allergic factors involved in such dermatoses as infantile eczema, atopic dermatitis, contact dermatitis, "id" reactions, drug eruptions, urticaria and angioneurotic edema are discussed. The recognition and management of these eruptions are reviewed in relation to the underlying specific sensitization mechanisms which play a part in their etiology.

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Dermatitis from Wearing Apparel

By Louis Schwartz, M.D.
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WHEN WE compare the occurence of dermatitis caused by wearing apparel with the hundreds of millions of people exposed, the percentage is insignificant, but occasionally comparatively large outbreaks have occurred, when materials processed with new chemicals of unknown toxicologic properties were placed on the market. By far the large majority of cases of dermatitis from wearing apparel occur as a result of allergy. Dermatitis has been reported from wearing apparel made of silk, wool, synthetic fabrics, leather, artificial leather, furs, rubber, and synthetic rubber. Articles of wearing apparel reported as causing dermatitis were dresses, coats, trousers, stockings, socks, pajamas, brassieres, dress shields, rubber gloves, and rubber girdles. Metals and alloys used in jewelry which is worn next to the skin, such as rings, earrings, wrist watches, and eye glass frames have also caused dermatitis. Plastics used in spectacle frames, wrist watch straps, garters, and suspenders have also been reported as causing dermatitis.

Dermatitis from Fabrics

Occasional cases of dermatitis have been reported as due to allergy to unprocessed natural silk and wool, but the majority of reported cases have been caused by processed fabrics.

Fabrics in wearing apparel consist of the basic fabric and all the chemicals remaining in it from the processing operations. The principal chemicals remaining in the fabric are the dyes, mordants, and finishes.

Urbach[5] describes a case of allergic contact dermatitis from unprocessed silk. Most of the other authors reporting cases of allergy to silk have not clearly stated whether the silk was or was not processed, except Schwartz and Peck.[4]

Allergic dermatitis has been reported from wool and camels hair.[4] No cases of dermatitis have been

reported from unprocessed cotton and linen, although dermatitis occurs among flax pickers and from cottonseed oil.

Fabrics are also made of synthetic resins, glass, and casein. Regenerated cellulose, cellulose acetate, polymers of hexamethylenediamine adipate, vinyl chloride, vinyl acetate, and styrene are all used as synthetic fabrics. While dermatitis has been reported among the wearers of synthetic fabrics, they all occurred from the finished product and not from the unprocessed material.

Fabrics made of glass are now being used for linings, and cases of dermatitis reported from them have been due mostly to the mechanical irritation of the sharp glass fibers.[3] Spun glass is also used for stuffing pillows and mattresses to make them nonallergenic. Some industrial dermatitis occurs among glass fiber makers from the resins used to make glass thread and wool.[3] Dermatitis reported from synthetic resin fabrics have been due either to the plasticisers, stabilizers, dyes, mordants, and finishes.[4]

Dermatitis from the dyes and mordants on fabrics has been heretofore comparatively infrequent. Recently, cases have occurred more frequently, and the dyes used on synthetic fibers have been the cause. Certain of the azo dyes used to dye nylon have been at fault. These dyes have the property of swelling and coating and entering the nylon fibers, and if they "bleed" out they can cause allergic dermatitis. Dyes which "bleed" are the ones which most often cause dermatitis. Perspiration may dissolve them out of the fabric. Faulty dyeing which fails to remove excess dyes, mordants, and oxidizing agents from the fabric predispose to dermatitis. The special dyes used on synthetic fibers have powers to swell and penetrate the fibers. It is possible that this property is what makes them penetrate, swell and irritate the skin.

Plasticisers and stabilizers used in synthetic plastic films and threads sometimes cause allergic dermatitis. In cases of dermatitis caused by vinyl resins (Elastiglass), both plasticisers and stabilizers were at fault. In an outbreak of dermatitis from rubber hydrochloride (Pliofilm), the stabilizer was found to be the cause.

The finishes on fabrics are the most frequent causes of dermatitis. Finishes are applied to fabrics to make them look better, feel better, give better wearing qualities, prevent "runs," prevent wrinkling, hold the crease, make them waterproof, flameproof, mothproof, moldproof, insectproof, and antiseptic. Some finishes are removed by laundering and must be reapplied. Such are the finishes of phenyl mercuric acetate which are being applied to diapers with the mistaken idea that they will prevent diaper rash. They may cause dermatitis. Some finishes, because they are not readily soluble in water, stay more or less permanently on the fabric.

Finishes of starch have not been reported to cause dermatitis. Improperly neutralized sulfonated castor oil finishes have caused dermatitis.[1]

Antiwrinkle, crease-holding and "run"-preventing finishes usually consist of emulsions or solutions of synthetic resins and are applied to the fabrics in the dye bath. The resins are not completely cured when first applied, the cure being completed either in the heat of the dye bath or by heating after dyeing. Completely cured water-insoluble resins rarely cause dermatitis, but if the cure is not completed, the uncured resins remaining on the fabric may cause dermatitis. Dermatitis has been reported from incompletely "cured" ester-gums, phenol-formaldehyde and urea-formaldehyde resin finishes, but any of the uncured resin finishes may cause dermatitis.

Waterproof Finishes.—The insoluble metallic soap finishes used as waterproofing agents have not been reported to cause dermatitis. But dermatitis has been reported from waterproof finishes consisting of Japan wax (derived from rhus vernicifera). Tar and the resins used to waterproof fabrics used for outdoor shelters have caused dermatitis only among workers processing them. The new silicone resins are now being used for water-repellent finishes.

Flameproofing Finishes.—Fabrics are treated with chloronaphthalenes, ammonium sulfamate, borates, or phosphates in order to make them flameproof. The chloronaphthalene finishes may cause chloracne, and the ammonium sulfamate may cause dermatitis.

Mothproofing Finishes.—Silico fluorides, naphthalene, chlorbenzene, and chlorphenols used as mothproofing may cause dermatitis, but such cases have not been reported.

Delousing Agents.—DDT (dichlor-diphenyl trichlorethane), pyrethrum, rotenone, lethane, and

the thiocyanates are the principal delousing agents, and they may all cause dermatitis.

Antimold Finishes.—Most of the commercial mildewproofing agents are primary skin irritants and sensitizers. Some of them have caused dermatitis even when used in extremely low concentrations. The phenyl mercuric salts, dihydroxy dichlorodiphenyl methane, tetra brom orthocresol, paranitrophenol, and the chlorphenols are examples of antimold fabric finishes which have caused dermatitis.

Leather

The incidence of dermatitis caused by wearing apparel made of leather is small. Dermatitis has been most frequently reported from shoes. Shoe polish has often been blamed, but it is difficult to conceive how the polish can go through the leather, through the adhesive, through the shoe backing, and through the stockings to contact the skin. The inner linings and backings of shoes are made to adhere to the leather by means of adhesives similar to that used on adhesive plaster. The inner linings, stocking guards, inner soles and tongues of shoes are often impregnated with antimildews and fungicides with the mistaken purpose of preventing "athletes foot." In the experience of the author, the fungicides have been the chief causes of dermatitis from shoes. If the shoe backing is made of dyed leather, then the dye may cause dermatitis.

The tanning agents such as chromates and the dyes used on the outside leather are possible skin irritants, but it is only under rare circumstances that they can penetrate through the backing, lining, and stockings to contact the skin. Suspected cases of dermatitis from shoes must be differentiated from dermatitis from the stockings and from tinea pedis, and must be confirmed by patch tests with the inner parts of the shoes as well as with the stockings that were worn at the time that the dermatitis developed. If the stockings are at fault, then patch tests with the part of the stocking that is above the shoe tops should be positive. If only the part of the stocking inside the shoe, and touching the inflamed area, gives a positive patch test, it must be suspected that the irritant has been absorbed by the stocking from the shoe. Patch tests should be performed with that part of the inner lining of the shoe which corresponds to the inflamed areas on the foot. These should be positive. In the rare cases where the dye or tanning agents used on the outside leather are at fault, the inner lining is discolored by the dye. In cases of tinea pedis, the vesicles located under the instep, the cracks and scaling between the toes, the positive cultures obtained from the blister fluid or cracks, and negative patch tests to the shoe linings complete the diagnosis.

Dermatitis has been reported from leather wrist watch straps,[2] where a dye (amido azo toluene hydrochloride) was found to be the irritant.

The possible irritant chemicals in leather are any of the fungicides, the dyes, the tanning agents, and the oils and resins used to finish the leather.

Dermatitis from hat bands is not infrequent. Hat bands causing dermatitis have usually consisted of "artificial leather." This may consist of a fabric or paper base impregnated with a mixture of cellulose nitrate or acetate, oils, resins, and rubber. Scrap leather may be mixed with oil, rubber, and pastes, and pressed together into sheets to make artificial leather. The possible irritants in artificial leather are the dyes, resins, antioxidants and accelerators.

Dermatitis has also been reported from leather gloves and pocketbooks.

Furs

The large majority of the cases of dermatitis from furs have been caused by paraphenylenediamine and the other oxidation dyes. A few cases may be due to the chrome mordants, the tanning agents used on the fleshy sides of the pelts, or the mechanical irritation of the skin caused by contact with coarse hair. In order to develop dermatitis from the dyes and mordants, the wearer must be sensitive to these chemicals before the fur is worn, in which case dermatitis develops a day or two after the fur is first worn, or must become sensitized by wearing the garment, in which case the dermatitis occurs a week or longer after the garment is worn. Poorly dyed furs, from which the perspiration leaches the dyes, are the usual causes of inducing sensitivity. Once a person is sensitized, even the wearing of a well-dyed fur may cause dermatitis.

Paraphenylenediamine is a white crystalline chemical soluble in water. It must be oxidized in order to become a dye. The first oxidation product is quinone diamine, an unstable compound which is the actual cause of the dermatitis. Further oxidation results in the formation of comparatively nonirritant chemicals.

In recent years, the incidence of dermatitis from

furs has greatly diminished because they dyers use weaker solutions of dyes for longer periods in order to permit better oxidation, and they are taking greater care to remove incompletely oxidized dye from the furs by better "drumming" and washing.

Feathers

Dermatitis from wearing feathers has not been reported, but mucous membrane allergy to feather pillows and bedding is not uncommon. A new fabric made of feathers will soon appear on the market, and we may expect some allergic manifestations from it.

Rubber

Rubber is extensively used in wearing apparel. Gloves, girdles, dress shields, elastic stockings, shoes, and boots are often made of rubber. Dermatitis has been reported from rubber gloves, girdles, and dress shields. Previous to the last war, natural rubber was used, but now only the synthetic rubbers are permitted to be used for these articles. Dermatitis has become more frequent from wearing rubber articles since the use of synthetic rubber began, because unlike natural rubber, the synthetic rubbers themselves contain sensitizing chemicals, and in addition, when processing them, the same accelerators, antioxidants, plasticisers, stabilizers, et cetera, are added which are the actual causes of allergic dermatitis from natural rubber. Dermatitis often occurs from gloves, dress shields, and girdles made of synthetic rubber. The girdles are made of both fabric-covered synthetic rubber threads, and of sheets of synthetic rubber. Phenyl beta naphthylamine, used both in making and processing synthetic rubber, is the most frequent actual cause of the dermatitis. The accelerators used to vulcanize the rubber, and the chemicals formed on the surface of the rubber by the action of the sulfur monochloride used in the "acid" or "vapor" cures, are also frequently the actual causes.

Jewelry

Most of the reported cases of dermatitis from jewelry have been attributed to nickel and chromium contained in alloys, but ornaments made of the synthetic resins may cause dermatitis. Earrings, necklaces, lockets, watches, and spectacle frames have been reported as causes of dermatitis. The fluxes used in soldering jewelry sometimes contain fluorides and zinc chloride which are skin irritants.

Diagnosis of Dermatitis from Wearing Apparel

Dermatitis caused by wearing apparel begins at the site of contact with the offending material, five days or more after the garment was first worn. This is the length of the period of incubation for the development of sensitivity. The dermatitis may appear before five days if the patient has been sensitized to the offending chemical in the garment by exposure from some other source previous to the time that the garment was first worn.

The eruption is usually sharply limited and confined to the areas of the skin which had been touched by the garment. In those exceptional cases where the eruption is more or less generalized, the garment may have touched all the affected parts or the eruption may be a toxic one, the result of absorption of the offending chemical through the skin to the body. In such cases, systemic symptoms such as elevation of body temperature may accompany the dermatitis. The eruption may be a simple erythema or it may be edematous, papular, and vesicular. A patch test, performed with a piece of the garment while the dermatitis is in the active stage, should be positive if the garment is the causative agent.

Patch tests should be performed by cutting away a piece of the material, about 1 inch square, applying it to an unaffected skin site of the patient, covering it with an insulating substance—such as non-waterproofed cellophane, 1.5 inches square—and fastening this to the skin with a piece of adhesive 3 inches square. A similar patch is also placed on a control subject. (Circular patches of the same diameter may be used.) Experience has taught the author that more positive reactions result from large patches than from small ones. The patches are removed after twenty-four hours and the reactions read. A positive patch test confirms the diagnosis. A positive patch test on the control as well shows that the material contains a primary irritant. A negative patch test on the control and positive one on the patient shows that the chemical in the material is a sensitizer.

To find the actual irritant chemical in the fabric, an attempt should be made to ascertain from the manufacturer the names and to obtain samples of the dyes and finishes used on the fabric so that the patient may be patch-tested separately with each of them. If the manufacturer refuses to sup-

ply the information and chemicals, the following procedure will roughly determine whether the dyes, finish, or fabric itself is at fault: Soak the fabric in warm, slightly acidified water for twenty-four hours. If the water becomes discolored, the dye bleeds and may be the actual irritant. Concentrate the solution by evaporation in vacuum to about one-tenth of its original volume; immerse a piece of surgical gauze 1 inch square in the concentrate and patch-test the patient with it. If the dye does not bleed and the water remains colorless, follow the same procedure. If the patch test with the dyed gauze is positive, the finish or dye is at fault. If the patch test with the undyed gauze is positive, then the water-soluble finish is at fault. If it is negative, then suspect a water-insoluble finish. If both patch tests are negative, then soak a piece of the fabric in ether for a few hours to extract the ether-soluble finish; pour off the ether into a large shallow dish or crystal and allow it to evaporate, and perform a patch test with the residue. If possible, obtain a piece of the unprocessed fabric and patch the patient with it in order to pick up the rare cases of sensitivity to the fabric itself.

Treatment

Once the diagnosis of dermatitis from wearing apparel is made, the treatment becomes simple. The offending garment should not be worn and only soothing medication applied. Unless complications (secondary infection, lichenification, et cetera) have already set in, all cases should soon get well.

There is no positive evidence that acquired sensitivity to a chemical will make the patient sensitive to other unrelated chemicals, and that as a result the dermatitis cannot be cured. If a case of dermatitis, said to be due to a certain article of wearing apparel, does not get well after the article is discarded and bland treatment is given, there is grave doubt cast on the diagnosis.

Prevention

Manufacturers should have all new synthetic fabrics or all new chemicals used for processing fabrics tested by the "prophetic" patch test,[4] before placing them on the market. This will prevent outbreaks of dermatitis such as have occasionally occurred. The isolated cases of dermatitis which occur from fabrics which are worn by millions without trouble cannot be prevented.

(References on Page 685)

A Cancer Cemetery

A Great Culture Medium

By Harold S. Hulbert, M.D.
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THE CREATION of a cancer cemetery, for the development and isolation of a natural anticancer biotic, is a new concept. Reference to it has not been found in the literature.

Molds, over the ages, have developed specific or limited appetites and the ability to survive at the expense of certain rather specific substances. An example is penicillin. A related example is *phage*. Throughout many generations of bacteriophage, an antityphoid phage may be fed dysentery bacilli in the laboratory until that particular strain of phage becomes able to dissolve B. dysenteriae and no longer lives on B. typhosus.

"Cancer has a life history." First, there is the anlage, often long dormant. Then budding occurs, then growth, and naturally (meaning if there is no surgical or radiation interference) great growth takes place at the expense of the host's body, which dies.

Then what happens? The host and its cancer, which also died, are buried. Here, we will assume that no embalming has been done. Buried, the body and the cancer are destroyed by worms. The cemetery worms die. Cemetery molds destroy the cemetery worms and complete the destruction of the cancer substances.

Which molds are the ultimate living biotics against cancer substance are not yet identified, but research *can* identify them. That is the point of this essay.

For a culture medium, there can be created a *cancer cemetery*. An old abandoned cemetery, partly swampy and partly drained, could be encased by an impervious wall forty feet deep, extending farther down than any form of life goes in the soil.

The topsoil can be enriched by buckets of earth flown to it from old semi-marshy cemeteries, e.g., those in New Orleans, where for a century un-

embalmed bodies have been buried. These buckets of cemetery soil would contain nonspecific cemetery worms and nonspecific cemetery molds. These buckets of soil could be spread on the top soil and covered with spadefuls of the dirt belonging to the walled-in cemetery. Thus the cancer cemetery may be prepared.

To it, from near and far, from surgical cases and autopsies, cancers can be brought to be buried. Breast cancers (not breasts with cancers but cancers dissected from breasts) can be planted in one corner of the cancer cemetery, cancers of the uterus in another area, and still other designated areas, cancers of certain other tissues could be buried. This procedure would be continued for a few years, which would mean many, many generations of cemetery worms and cemetery molds.

Then would come the first step toward identification. Some new breast cancers can be buried in the breast-cancer area, but buried diagonally so that part of the tissue is under the topsoil and part of the tissue is above the surface, exposed to the air. When the tissue is moldy, both the part under the surface of the dirt and the part above the dirt, the molds on it can be identified by a mycologist in his laboratory. Repeated examinations may show that certain strains of molds are generally found on or near breast cancers. They may be cultivated in the laboratory, and in boxes in its yard or greenhouse, on dirt which has been cooked until sterile and mixed with minced fresh breast-cancer tissue. When the molds have become specific against *breast* cancer, they can be cultivated further by ordinary mold-laboratory techniques, and the anticancer biotic fraction extracted for therapeutic use, much as penicillin is extracted from penicillium mold cultures.

Conclusions

1. In nature, in the life history of cancer there is a *natural* end of cancers: *the natural end is not the death bed but is in the cemetery.*

2. The *only* natural source of crude anticancer biotic is in cemetery molds, which have eaten the dead bodies of cemetery worms, which have eaten not only the bodies of persons who died of cancer but also the cancers in those bodies. (Reference is made to unembalmed bodies).

3. A *cancer cemetery,* as described above, used as a culture plate and culture medium, can furnish the crude anticancer molds; and under controlled cultivation in prepared soil, as outlined, these molds can be grown in sufficient quantities to be identified. Recent advances in science, such as penicillium cultures and the culturing of phage to new specificity, open a vista and point out to research the way to culture these anticancer molds until a therapeutic anticancer biotic can be isolated.

4. The refinement of specific anticancer biotics for therapeutic use against specific types of cancer in specific tissues, e.g., carcinoma of the breast, uterus, et cetera, can be done in tiny, synthetic, laboratory *cancer cemeteries,* like a green house.

5. Such a research task is practical now but would be expensive and take time, and would need several well-co-ordinated teams of diversified workers. It would need the co-operation of local hospitals, especially their surgeons and pathologists; the active support of many other doctors, including rural family physicians with their knowledge of rural cemeteries and family histories; and the talents of the mycologists and biochemists of great pharmaceutical and industrial firms.

30 North Michigan Avenue

MSMS

Under the now expiring Emergency Maternity and Infant care program, about $125,000,000 of federal money was spent, of which about $60,000,000 went for hospital care.

THE CORNELIAN CORNER

(Continued from Page 619)

ages the expectant father to accompany his wife on her first visit to the obstetrician and learn directly about her needs during the prenatal period so that he can share her experience with her and understand how to assist her toward becoming a good mother. The sense of well-being and the emotional security of every expectant mother is determined very largely by her husband's attitude.

Through its efforts to have the newborn infant in the same room with its mother from the time of birth, the Cornelian Corner hopes to make it possible for the father of the child to visit as often as he can. It encourages him to hold his infant so that he, too, may begin to love his child as early as possible. The Cornelian Corner is, finally, a mental hygiene project which aims to promote better parent-child relationships.

Postoperative Foreign Bodies in the Abdomen

By Edward S. Zawadzki, M.D. and
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A SPONGE left in the abdomen following an operation usually has unpleasant complications and may be a diagnostic problem in the later life of the patient. This accident is not uncommon. Crossen and Crossen,[1] in an exhaustive review of the literature from 1859 to 1940, found 307 cases, and they feel that these represent but a fraction of the actual number. According to these authors, the symptoms due to a sponge left in the abdomen are variable. Usually they manifest themselves in the immediate postoperative period, although not infrequently they may not occur for months or even years. It is rare, however, that a sponge be retained more than five years. Crossen and Crossen[1] report fourteen such instances. Walker and Coburn[4] report one case where the sponge was found twenty-seven years after operation. We wish to report two cases in which sponges were retained in the abdomen, in one instance for twenty-eight years and the other for twenty-three years.

Case Reports

Case 1.—A sixty-four-year-old white housewife was admitted to the hospital on August 14, 1946, complaining of pain and swelling of the abdomen. In October, 1945, she had an episode of intestinal obstruction which was relieved by medical means. At that time a constricting lesion of the splenic flexure of the colon was diagnosed roentgenologically following a barium enema. She again had episodes of obstruction in March and July, 1946, which were also relieved by medical treatment. Roentgenograms after each episode revealed the lesion of the colon to be progressing. The patient finally agreed to an exploratory laparotomy.

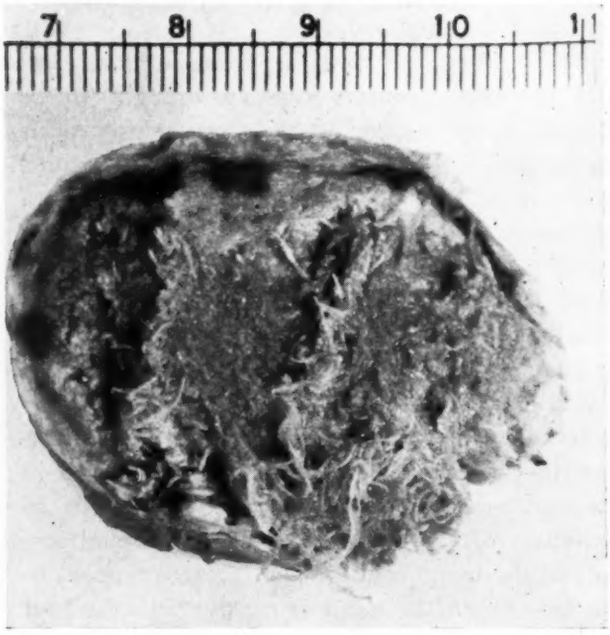

Fig. 1. Encapsulated sponge found in the abdomen of the patient in Case 1.

She had been under treatment for diabetes mellitus since 1940. A dilatation and curettage was performed in 1906 and a hysterectomy for uterine leiomyomata in 1918. There had been no abdominal complaints until the episode of obstruction in 1945.

On physical examination, a hard movable mass was palpated in the left upper quadrant of the abdomen; this was thought to be the obstructing lesion found on roentgenograms.

The abdomen was opened by an upper left rectus incision. A cystic mass measuring 5 cm. in diameter was found related to the jejunum and its mesentery. This was removed but during the dissection the bowel was entered at the point of attachment. It was uncertain whether the cavity of the structure was in communication with the lumen of the bowel. On further investigation the lesion of the splenic flexure of the colon was found, resected, and the intestine repaired by end-to-end anastomosis. The patient made an uneventful recovery and was discharged on September 7, 1946.

The specimen from the jejunum was a somewhat oval cystic mass, 5 cm. in diameter, filled with brownish solid material containing threads or hairs. On section the cyst wall was mottled yellow and red and measured up to 3 mm. in thickness. After the specimen had been in formalin for several days the mesh of a gauze sponge could be recognized (Fig. 1).

On microscipic examination, the cystic mass was composed of a central mass of amorphous eosinophilic

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material in which cotton fibers could be recognized. The wall of the cyst was composed of fibrous connective tissue which was mostly hyalinized. Near this living portion there was calcium deposition on cotton fibers. There were areas of old hemorrhage with cholesterol-

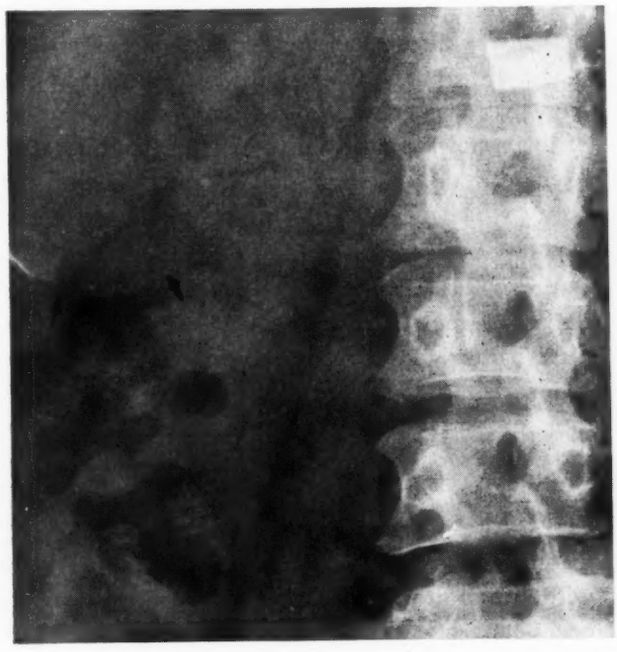

Fig. 2. X-ray shows calcium shadow due to encapsulated sponge in the region of the gall bladder. Case 2.

crystal clefts and surrounding foreign-body giant-cell reaction.

The lesion in the colon was an adenocarcinoma with extension to the pericolic tissues and lymph nodes.

Case 2.—A fifty-three-year-old white housewife entered the hospital on April 22, 1947, complaining of pain in the abdomen after meals, much gas, vomiting, and nervousness. Twenty-three years previously she had an appendectomy and removal of gallstones.

On physical examination there were well-healed ancient right lower and right upper quadrant abdominal surgical scars. No masses or enlarged organs were palpated. There was slight tenderness in the right upper quadrant of the abdomen and in the right costovertebral angle.

Retrograde pyelograms were normal, but with oral cholecystograms there was evidence of a nonfunctioning gall bladder. In the right upper quadrant of the abdomen, in the region of the gall bladder, there was an incomplete circular shadow of calcium density, 5.5 cm. in diameter (Fig. 2).

At operation a large cystic mass was found and removed from the vicinity of the gall bladder. After freeing numerous adhesions beneath this mass, the gall bladder was identified and removed. It contained several small stones. The patient made an uneventful recovery and was discharged May 13, 1947.

The cystic mass measured 14 cm. in greatest dimension and had a fibrous capsule covered by numerous tissue tags. The wall was calcified in areas. Centrally, the cotton fibers of a sponge could be recognized, intermixed with necrotic material (Fig. 3). Microscopically

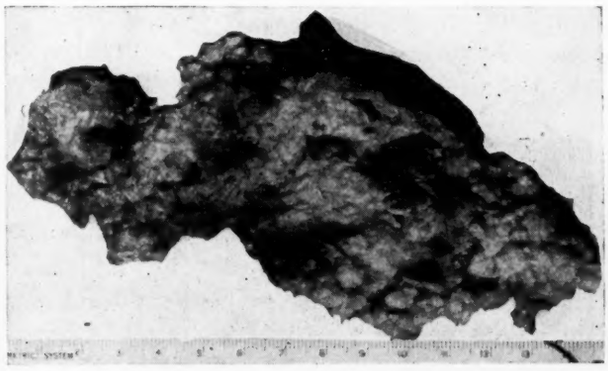

Fig. 3. Encapsulated sponge found in the abdomen of the patient in Case 2.

the wall was composed of dense hyaline connective tissue with areas of calcium deposition along the inner surface. There were numerous phagocytes present along this surface. Within the cavity, cotton fibers as well as necrotic and degenerating material were identified.

The gall bladder revealed chronic cholecystitis and cholelithiasis.

Discussion

In the first case, the sponge was a complete surprise and its nature was not immediately recognized. Its attachment to the jejunum suggested a diverticulum, and its gross appearance at the operating table suggested a dermoid cyst. Only after cross section was its true nature discovered. It is probable that this was the mass palpated prior to operation. The patient did not recall any symptoms that could be ascribed to the presence of this intra-abdominal foreign body.

In the second case, it is possible that some of the abdominal distress of the patient could be ascribed to the foreign body, although a diseased gall bladder was also present. In contrast to the first case, sufficient calcium was present in the cyst wall to be detected radiographically although no specific diagnosis could be made. The sponge was recognized readily at the operating table. It had been present in the abdomen for twenty-three years.

Both cases are unusual in the length of time that the sponges had been retained with little, if any, evidence of their presence. Had these sponges contained radiopaque threads, as advocated by

(Continued on Page 639)

Vertigo

Differential Diagnosis and Treatment

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THE NAME of Ménière has become generally associated with attacks of dizziness or vertigo since the description of his famous case in 1861. The terms Ménière's disease, Ménière's syndrome or symptom complex, and pseudo-Ménière's syndrome are all in common use at the present time. Any discussion of the subject of vertigo requires a definition of what is meant by these terms.

The name Ménière is associated only with that type of vertigo which produces a sense of motion either of the environment or the individual, usually of a rotational character but sometimes in a lateral or downward direction.

It does not apply to the sense of giddiness or dizziness which accompanies certain ocular disturbances or a loss of muscle and joint sense.

After Ménière's original description, the term Ménière's disease was apparently applied to the apoplectic type of vertigo and deafness which occasionally occurred in a previously normal ear. A vascular accident in the labyrinth was considered to be the etiology. Gradually it became apparent that a vascular lesion could not explain the majority of cases of vertigo, deafness and tinnitus, and that undoubtedly several causes were to be considered. The term Ménière's syndrome or symptom complex therefore received general preference, and continues in use as a term which embraces the occurrence of vertigo, deafness and tinnitus in the form of a single or repeated attacks. Suppurative labyrinthitis, acoustic tumors and traumatic injury were usually not included, since the etiology in these cases could be definitely determined. Since the acoustic and vestibular portions of the eighth nerve separate upon entry into the brain stem, the combination of auditory symptoms with vertigo is therefore indicative of a disease or lesion affecting the peripheral labyrinth or eighth nerve.

The term Ménière's disease has again come into common use in reference to one particular clinical group. This group is characterized by recurring vertigo in the form of attacks associated with deafness and tinnitus of a fluctuating type. The pathologic disturbance in this group has been found to be a hydrops or dropsy of the labyrinth (dilatation of the endolymphatic fluid system of the inner ear). Ménière's disease therefore refers to one disease entity which gives rise to the general syndrome of Ménière.

Vertigo is also a symptom of many types of disease of the central nervous system, arising from disturbances of the central vestibular nuclei and pathways. It is therefore a common symptom in disease involving the posterior cranial fossa, and in such cases is usually not accompanied by deafness.

It is also possible that vertigo may arise from a disturbance of the vestibular apparatus in the ear without auditory symptoms. This occurs in the occasional case of labyrinthine dropsy. However, the auditory sense organ is more susceptible to injury than the vestibular receptor apparatus, and it is probably only in rare instances that vertigo is produced by inner ear disease without also having some degrees of deafness or tinnitus or both.

In everyday experience, the occurrence of vertigo in the form of an attack without auditory or other localizing nervous signs is found to be as common as the occurrence of the complete Ménière's syndrome. Such attacks are commonly referred to as pseudo-Ménière's syndrome.

Pseudo-Ménière's Syndrome

Because of the absence of auditory symptoms, vertigo of this type cannot be definitely localized to the peripheral vestibular mechanism. A true Ménière's disease (labyrinthine dropsy) has begun in an occasional case as a pseudo-Ménière's syndrome, the auditory symptoms appearing after a few weeks or months, but such cases are infrequent.

Vertigo without other localizing signs has been sometimes observed as the earliest sign of tumor, multiple sclerosis, or inflammatory disease in the posterior fossa, and may be the predominant symptom of posttraumatic syndrome.

In such cases the diagnosis is made possible by the history or the associated symptoms and signs

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which eventually appear, but certain characteristics of the vertigo appear to be of significance in localization.

It has been found that when the central vestibular system is the site of the disease, the vertigo in the majority of cases is either brought on or greatly influenced by changes in posture, and is therefore known as a "postural vertigo."

The postural character can be brought out in the history. Such patients quickly find that certain positions of the head or certain movements bring on the vertigo, while it may be avoided by keeping the head completely quiet or in certain positions. The vertigo which arises from the vestibular system is accompanied by nystagmus; therefore, the routine test for postural vertigo and nystagmus is likely to be the most revealing part of the examination.

Attempts have been made to classify the types of positional nystagmus found on these routine tests and to localize the origin to the peripheral or central vestibular mechanism on that basis.

It appears that when the nystagmus can be reversed by changing the position of the patient, the disease lies in the central apparatus. However, in cases where a reversal does not occur, but only a reduction or disappearance of the nystagmus, or possibly a slight variation in direction, the sign may not be helpful in localization.

The tests for vestibular excitability are frequently of no value in pseudo-Ménière's syndrome, since they are most often normal, but may be symmetrically reduced or may be asymmetrical responses without giving reliable aid to localization.

The vertigo in pseudo-Ménière's syndrome is of the postural type in the majority of cases, although in some it may be a constant vertigo during the initial severe stage, becoming postural as the symptom abates.

While such diseases as early labyrinthine dropsy, early tumor and multiple sclerosis must always be considered, it is found that the syndrome is due most frequently to other causes affecting the central vestibular apparatus.

These conditions, which appear to explain the vertigo in the majority of these cases, may be grouped as follows:

1. Cerebral arteriosclerosis and hypertension.

2. Toxic manifestation, either of a low-grade infection, probably of the virus type in most instances, or of certain drugs such as alcohol or streptomycin.

3. Vasomotor insufficiency. Under this heading can be included the vertigo that is common at the onset of the menopause as well as the relatively common group in which a single or repeated attacks of postural vertigo seem to be related to an abnormally low or labile blood pressure and other vasomotor disturbances.

The prognosis for relief of the vertigo in such cases is always good, and the matter of localization is fortunately not of grave importance.

The treatment consists in absolute rest, avoiding movement of the head, mild sedation, and treatment of the underlying etiologic factor.

Ménière's Syndrome

The term Ménière's syndrome is not customarily used when an etiologic diagnosis can be made; hence labyrinthitis, acoustic neurinoma, and traumatic injury are not included. However, in some instances the diagnosis of even these conditions may present difficulties. For example:

An attic cholesteatoma with a small perforation in Shrapnell's membrane may produce a labyrinthitis and yet escape detection by the unskilled observer. Or an acoustic neurinoma in the early stage may be confused with hydrops of the labyrinth. Repeated examinations will, however, demonstrate the absence of vestibular responses, the eventual involvement of other cranial nerves, and possibly dilatation of the internal auditory meatus on roentgenographic examination in the case of acoustic neurinona or cerebellopontine angle tumor.

Trauma of the head, with or without fracture, may result in concussion of the inner ear on one or both sides and the onset of profound loss of function, which comes on some hours after the injury. Recovery is usually incomplete and may require several weeks. It is known that in animals subjected to measured blows on the head, free hemorrhage occurs into the tissues of the modiolus and to some extent in the fluid spaces of the inner ear; hence, the disturbance of function may be related to hemorrhage.

Those conditions which are sometimes included under Ménière's syndrome in its present interpretation include the following:

1. Labyrinthine fistula. Cholesteatoma in the attic and aditus is the common cause, but the symptom is common in congenital syphilis which

involves the ear, and may occur in rare cases of granuloma or tumor of the temporal bone. It can be detected by the production of vertigo and nystagmus on increasing and decreasing the air pressure in the external auditory meatus.

2. Nonsuppurative otitis media is also a relatively rare cause for an attack of vertigo. The acute or subacute tubal blockage with exudative catarrh (middle ear completely filled with fluid) sometimes is associated with vertigo, which may be relieved by incision of the drum and removal of the fluid by tubal inflation.

3. Toxic neuritis or neuro-labyrinthitis. The cochlear apparatus is more sensitive to toxic processes than the vestibular sense organs; hence, severe damage to the auditory mechanism may be produced with relatively little vertigo. The deafness which sometimes follows mumps is a classic example of a toxic neuritis. Fortunately, it is nearly always unilateral. Vertigo may be present for a few days at the onset but vestibular function is not impaired. A similar toxic degenerative type of deafness may follow other acute infectious diseases. Deafness and vertigo may accompany a geniculate ganglionitis and may occur in a polyneuritis of infectious origin associated with parotitis and uveitis.

A number of drugs have been know to bring on tinnitus, impaired hearing and vertigo. Quinine, salicylates, tobacco in rare cases, and streptomycin in large dosages are examples.

4. Hemorrhage and thrombosis. Hemorrhage has been found in the fluid spaces of the inner ear in some cases of advanced leukemia. The original case reported by Ménière probably belongs to this group, since the death of his patient was otherwise not explained.

The sudden onset of severe tinnitus, deafness and vertigo in a previously normal ear, with resulting gradual recovery from vertigo but a profound and permanent impairment of hearing, is occasionally seen in people of the fourth decade of life or later. Such a single episode, occurring without evidence of infection or demonstrable systemic illness, suggests some type of vascular lesion as the most probable explanation. Histopathologic proof is still lacking. Such attacks do not recur. They may be of varying severity. In some cases there is profound deafness. In others the resulting deafness may be less profound, and in some of these the vertigo has been known to persist for several years when the patient assumed certain positions. Some cases are seen where vertigo does not occur, but deafness and tinnitus appear in the same sudden manner, and a permanent nonprogressive high-tone deafness may result.

It appears likely that these different degrees of impairment represent variations in the same type of inner ear pathology.

5. Allergy. The occurrence of deafness and vertigo has been observed along with an acute allergic reaction and may be recurring. The way in which the inner ear is affected is not definite. The question arises as to the relation of an allergic reaction to labyrinthine dropsy (idiopathic Ménière's disease), but on clinical observation there is little evidence to associate the two. The treatment consists in recognition of the allergen and elimination or desensitization.

6. Labyrinthine dropsy (Ménière's disease). The majority of cases of Ménière's syndrome fall into this group. The clinical characteristics are recurring attacks of vertigo, associated with tinnitus and deafness.

The vertigo varies in severity and duration. The onset may be sudden or gradual, either without warning or preceded by steadily increasing deafness, tinnitus and a feeling of blockage in the ear. The attacks may be frequent or infrequent. They may occur several times weekly and disappear for months at a time without evident reason. There is excellent evidence that some patients with the disease may not get the vertigo but have only the characteristic type of auditory disturbances. The hearing impairment associated with hydrops starts as a low-tone loss for both air and bone conduction. Fluctuation in the threshold occurs from week to week, sometimes as much as 35 decibels variation occurring within a day or two. The disease appears usually in the fifth decade, but may appear earlier or later. In about half, the occurrence of hydrops with vertigo and low-tone deafness is preceded by bilateral high-tone progressive deafness. In younger people, however, the disease appears without pre-existing high-tone deafness. The hearing loss tends to be progressive, and in more advanced stages high-tone thresholds are reduced along with those for low tones. The deafness may become profound within a few years or may decrease more slowly. Noises are troublesome, and are usually a low-pitched roaring type, varying with the deafness. An intermittent dipla-

cusis or an unpleasant disturbance of pitch perception is common. Bone conduction is reduced along with air conduction and fluctuates with it. The Rinne test remains positive.

The condition is unilateral in the majority but bilateral in from 10 to 15 per cent.

The tests for vestibular function are usually about normal in early stages, but a gradual decrease in caloric response is usually found in advanced stages. The responses may also be greatly reduced at one testing and normal at a later examination.

A postural effect on the vertigo may occur and, when present, consists usually of an increase in vertigo and nystagmus in certain positions. The direction of the nystagmus varies little, however, in contradistinction to most cases of pseudo-Ménière's syndrome.

The pathologic condition in the inner ear consists in a dilatation of the endolymphatic fluid system. The dilatation is irregular because of the variations in thickness of the membranous walls, and varies somewhat from case to case. The sensory organs which are located within the endolymphatic system are affected by the physical distortion of the structures, probably also by pressure changes, and in late stages some degenerative changes are found in the neural apparatus. The etiology and pathogenesis remain obscure as yet. However, the most likely explanation is that the increase in quantity of endolymph is due to some disturbance of the secretory mechanism. No sign of inflammatory reaction is evident, with no cellular infiltration, and no change in the staining characteristics of the fluid.

The tendency for Ménière's disease to be associated with headaches, and in younger age period with low blood pressure and gastrointestinal complaints suggests a vasomotor disturbance in the ear as a causative factor.

Treatment

Medical

The medical treatment which seems to give best results is directed toward maintaining an even fluid balance and preventing temporary increases in the amount of endolymph. Such measures as restriction of fluid, a salt-free or sodium-free diet and the use of mild diuretics appear to be indicated.

The sodium-free diet recommended by Fursten-burg, Lashmet and Lathrop, accompanied by ammonium chloride, 6 to 9 gm. daily for alternate three-day periods, has given fair results.

The ammonium chloride is given during each meal in equally divided doses for a period of six weeks, repeating the course in alternate six week periods.

A low salt diet accompanied by potassium chloride, two teaspoonfuls of a 25 per cent solution twice daily with the meal, as introduced by Talbot and Brown, has been found practical and useful.

Better results are obtained if the medical treatment is accompanied by attention to the patient's habits. Even distribution of the food and fluid intake during the day, reduction in the working hours, adequate time to rest and mild sedation are helpful.

Inflation of eustachian tubes in cases of labyrinthine dropsy has not been of value.

Histamine therapy has been widely used. Intravenous injection of histamine according to Horton's method, 2.75 mg. of histamine diacid phosphate in 250 c.c. of normal saline in a period of one and a half hours or more, has been useful in relieving an attack of vertigo. The effect appears to be in some way due to the vasodilator effect of histamine.

I have not been able to satisfy myself that subsequent attacks could be prevented by subcutaneous injections of histamine several times weekly.

The theory that a patient may be desensitized to histamine seems to have been refuted.

Nicotinic acid has also been a popular method of therapy.

Many drugs have been used for treatment of this disease, including atrophine, pilocarpine, epinephrine, and saline laxative. The antihistamine drugs, benadryl and pyribenzamine, do not appear to have produced definite results as yet. The general experience has been that the attacks of vertigo could be more or less alleviated in the majority of cases by medical treatment.

Patients are more concerned with the prevention of vertigo than with the auditory difficulty, unless both ears are involved, when the deafness may become a serious handicap.

In about 10 per cent of cases, because of failure of medical therapy and the hazard involved in certain occupations in case of vertigo, some form of surgery is justifiable.

Surgical

1. Intracranial section of the vestibular portion of the eighth nerve was introduced by McKenzie of Toronto and has since been carried out on a large series of cases by Dandy. Although the operation is ideal in that the auditory division of the nerve is spared and reported results have been good, the operation has not been free from complications, and the tendency on the part of most neurosurgeons seems to be to reserve it for carefully selected cases.

2. Various surgical procedures have been performed on the labyrinth for this condition.

Portmann's operation, opening the endolymphatic sac, has given only partial success. Experiments indicate that the operation has no rational basis.

Injection of alcohol into the labyrinth destroys hearing as well as preventing the attacks of vertigo, but has also caused a facial palsy.

A labyrinthotomy with destruction of the endolymphatic labyrinth either by evulsion, instrumentation or coagulation within the canal and vestibule, has proven to be a simple and safe way of preventing further vertigo. However, the hearing has been destroyed in almost all cases. The operation is not suitable therefore for the bilateral cases but has been satisfactory from the patient's viewpoint in unilateral cases, since the hearing had already been greatly depressed before operation.

Varying degrees of relief from the noises in the ear have been obtained.

Summary

1. Attacks of vertigo of the type which arises from the vestibular apparatus are usually associated with the name of Ménière.

2. The terms Ménière's disease, Ménière's syndrome or symptom complex, and pseudo-Ménière's syndrome are defined.

3. The differential diagnosis in the presence of pseudo-Ménière's syndrome is discussed.

4. The various inner ear conditions which may produce Ménière's syndrome or symptom complex are discussed.

5. Labyrinthine dropsy or Ménière's disease, which is the most common cause of Ménière's syndrome, is discussed in some detail.

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Hemometakinesia

Therapeutic Application to Peripheral Vascular Disease

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THE CONCEPT of hemodynamics, to which the term hemometakinesia has been applied, provides, it is believed, a more rational approach to the management of certain forms of peripheral vascular disease than now exists.[5,9] This concept is based on certain observations concerning the physiology of the circulation which established the presence of spontaneous and even rhythmic fluctuations in the volume of organs, primarily attributable to changes in the volume of the blood within the part. These observations, which suggest that there is a continuous shifting back and forth of blood from one part of the body to another, seem to indicate the existence of a well regulated "borrowing-lending" mechanism which permits the body to utilize its limited blood volume in the most effective manner to meet variations in local requirements.

To permit a better understanding of this new concept and of its therapeutic significance in peripheral vascular disease, it is necessary to outline briefly some of the studies and observations which have led to its formulation.

It has been a well-established fact for a long time that the volume of organs undergoes spontaneous and even rhythmic variations, which are attributed essentially to changes in the volume of the vascular bed of the part and which thus reflect variations in the behavior of the local circulation. With the recent development of more refined techniques of plethysmography, it has been possible to make more precise quantitative studies of the fluctuations in volumes in such peripheral

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parts as the fingers, toes and pinnae. These studies have contributed much useful knowledge of the mechanisms of the peripheral circulation in health as well as in disease.

It has been demonstrated by means of the plethysmograph that spontaneous variations in volume occur in the small blood vessels of such peripheral areas as the pinnae, fingers and toes.[1,2] At least five types of rhythmic changes in volume, ranging from less than 0.1 to 350 cu. mm. or more per 5 c.c. of part, have been noted in the normal person resting in comfortable surroundings, as follows:

1. Pulse deflections, which represent the changes in volume of the part produced by the blood delivered into the part with each heart beat.

2. Respiratory deflections, which represent variations in volume (from less than 0.1 to 5 cu. mm. per 5 c.c. of part) occurring with the normal respiratory cycle. They are chiefly contingent upon variations in venous return to the heart produced by respiration.

3. Alpha deflections, which are primarily controlled by the sympathetic nervous system although they are independent of variations in arterial pressure. They occur less frequently than respiratory deflections. They usually have smooth, though not necessarily uniform, contours, and they vary in frequency and size, with a tendency toward an inverse relationship.

4. Beta deflections, which are larger changes in volume upon which a succession of smaller alpha deflections is superimposed. They vary in volume from 5 to 60 cu. mm. per c.c. of part and they have a frequency range of from one to two per minute. Although they possess a totally irregular frequency and volume, they tend to vary concordantly in the fingers, toes and pinnae.

5. Gamma deflections, which are probably concerned with large and usually comparatively slow shifts in blood from one part of the body to another. They develop more slowly than any of the other deflections; they vary in frequency from one to eight per hour and in volume from 50 to 350 cu. mm. per 5 c.c. of part. They are primarily due to changes in volume of the vascular bed of the part, with variations in lymph volume probably contributing significantly to the volume change.

The different types of volume deflection observed in the normal plethysmogram may be affected by a number of factors. These factors produce variations of considerable degree, which may resemble the changes found in diseased states. Among the factors which may produce changes reflecting the behavior of the peripheral circulation in response to external and internal stimuli are the psychic state of the individual, the environmental temperature, the relation of the part to heart level, and the presence or absence of intact sympathetic pathways to the part.

The psychic state of the individual affects particularly the pulse and alpha deflections, probably as a result of increased sympathetic activity. Thus, fear, anxiety or tension tend to diminish the pulse and alpha deflections and to increase the rate of the pulse deflections.[3,6]

Changes in environmental temperature may profoundly affect the spontaneous volume deflections. Thus, chilling, by producing vasoconstriction, reduces the volume of the pulse and the alpha deflections and, if it is prolonged, may cause the occurrence of a negative gamma deflection, which indicates a decrease in the volume of the part. Heating, on the other hand, produces vasodilatation, with a consequent increase in the volume of pulse deflection. After full vasodilatation, the increase in the volume of pulse deflection is followed by a decrease in alpha deflections, and then by a positive gamma deflection, indicating an over-all increase in the volume of the part. These reactions are a good guide to the diagnosis of organic occlusive arterial and arteriolar disease, since vasodilating responses are impaired or absent in patients with such conditions as thromboangiitis or obliterating arteriosclerotic endarteritis. The effort to produce vasodilatation in the tips of the fingers or toes by the application of heat to another extremity tests the patency of the arteries and peripheral blood vessels to the part under investigation, as well as its neurovascular mechanism.

Spontaneous volume deflections are also influenced by the position of the part in reference to the heart level. If the part is placed below heart level, there is a decrease in the volume of pulse and alpha deflections. A positive gamma deflection is produced by the pooling of blood and lymph in the dependent part as the result of gravity. Arteriolar constriction, either alone or in combination with distention of the vessels secondary to increased venous pressure, with a reduction in further distensibility of the vascular wall, has been suggested to explain this phenomenon.[4] The opposite effect

is obviously obtained by raising the part above heart level. To obtain standard recordings, therefore, the part should be maintained at or near heart level.

Finally, interruption of the sympathetic pathways will alter spontaneous volume deflections. The volume of the pulse deflections, for example, increases considerably and the alpha deflections virtually disappear within a few minutes after infiltration of 1 per cent solution of procaine hydrochloride into the regional sympathetic nerves or ganglia. A large positive gamma deflection is produced by engorgement of the vascular bed within the part after sympathetic block. By means of sympathetic block, therefore, it is possible to determine the degree of the normal, or, in certain conditions, of the abnormal, vasoconstrictor tone and the extent of vasodilatation or the general order of the amount of increase in vascularity of the part that can be achieved by interruption of these pathways.[7,8]

On the basis of these plethysmographic observations, as well as on the basis of other studies showing comparable changes in the volume of certain internal organs, it is evident that spontaneous variations are constantly occurring in the volume of the vascular bed in different parts of the body. These fluctuations may be rhythmic, concordant, or discordant, and they are apparently influenced by a number of factors. They suggest a continuous shifting of the blood from one part of the body to another, a sort of "borrowing-lending" phenomenon, to meet local requirements. Certainly they reflect a well-regulated mechanism which seems to be concerned with vital physiologic adjustments and which seems to have definite order and significance.

It seems reasonable to assume that at least a part of the possible significance of these changes lies in an attempt by the body mechanism to make the most efficient use of the total blood volume in meeting the variable requirements for blood for different parts of the body. The total blood volume is too small to meet the maximum demand of all the tissues at the same time, but it is more than adequate to accommodate isolated parts urgently requiring large quantities of blood at certain times. Under normal conditions the total blood volume is relatively constant, although considerable variation in the vascular bed, especially in isolated parts of the body, can occur within a comparatively short time. Within a matter of minutes the volume of the vascular bed in a certain part of the body, such as a finger or a toe, may be observed to increase greatly, sometimes to as much as double its original size. Obviously, the additional blood required to fill the augmented vascular bed must come from some source. Since the total blood volume is relatively constant, it seems reasonable to believe that the local increase was taken from the bed of some other part or parts of the body. If the volume of the vascular bed in one part of the body is increased by a certain amount, and if the volume of the bed in other parts of the body is simultaneously decreased by the same amount, no change is required to take place in either the blood volume or the cardiac output. The only change required to achieve this purpose is an adjustment in the vascular beds of different parts of the body.

What occurs, in other words, is actually a borrowing of blood in one part of the body and a lending of blood in other parts. This phenomenon constitutes the essential features of the concept of hemometakinesia. The essence of the mechanism seems to lie in the control and regulation of the vascular bed which permit an increase in the volume of blood of one part of the body and a corresponding simultaneous decrease in the volume of blood of other parts. It should be realized that the amount contributed for lending purposes by individual parts of the body may be relatively small. The major part probably comes from the larger vessels within the organism, though all the vessels may participate in the contribution.

This borrowing-lending phenomenon has been repeatedly demonstrated in normal persons as well as in patients with peripheral vascular disease by thermometric and plethysmographic studies under controlled atmospheric conditions, in a room built to reduce psychic disturbances.[5,9] Illustrative cases have been cited in previous publications.[5,9]

Therapeutic Implications of Hemometakinesia

The principles of hemodynamics which constitute the basis of the concept of hemometakinesia are thought to have a direct therapeutic application to peripheral vascular disease. In such conditions there is a reduction below normal in the mount of circulating blood to a part. Therapy, to be effective and to provide improvement in the local circulation, must obviously be directed toward securing an increase in the blood supply to the part. This objective requires an increase in the

volume of the vascular bed of the part, which can be achieved by vasodilatation.

Various measures have been proposed for this purpose, but most of them, including, in particular, drugs and chemical agents administered systemically, produce varying degrees of generalized vasodilatation. In most peripheral vascular disturbances, however, the diminution in circulation is localized to one or two peripheral parts, and the primary objective of therapy is to provide maximum vasodilatation in these localized areas of involvement.

In the light of the principles of hemodynamics just described, it appears irrational to employ therapeutic measures designed to produce dilatation of the entire vascular bed in conditions in which the diseased state is localized to one or two peripheral parts. Moreover, their efficacy is dubious. The possible production of maximum generalized vasodilatation would create a serious disproportion between the augmented total volume of the vascular bed and the relatively fixed total volume of blood. Indeed, since the total blood volume is relatively fixed, the only means by which it becomes possible to increase the circulating blood volume in any localized area when there is a comparable increase in the entire vascular bed is by an increase in cardiac output, the desirability of which is decidedly open to question.

The therapeutic approach which conforms best with the concept of hemometakinesia consists in the production of local vasodilatation limited essenitally to the part in need of more blood. This is best achieved by interruption of the sympathetic pathways to the affected part. Both in theory and in practice this is the most effective method of producing a maximum increase in the blood supply to the diseased part. In an extensive experience, which covers many years, there has yet to be found a general vasodilator which can produce in a local peripheral part vasodilatation equal in degree or duration to that produced by sympathetic denervation of the part. Other measures may produce varying degrees of transitory increase in the blood supply of a diseased part, but sympathectomy is the only means by which a maximum and relatively permanent improvement in the local circulation can be effected.

Summary

Plethysmographic observations and other studies indicate that spontaneous variations are constantly occurring in the volume of the vascular bed of different parts of the body. The term hemometakinesia has been applied to this continuous shifting of the blood from one part of the body to another, which is, in effect, a sort of "borrow-lending" mechanism to meet varying local requirements. The therapeutic implications of this new concept of hemodynamics are particularly applicable to peripheral vascular disease. They support the belief, already thoroughly tested by clinical experience, that although other measures may produce varying degrees of transitory increase in the blood supply of a part, which is the objective of the therapy of peripheral vascular disease, sympathectomy is the only means by which maximum and relatively permanent improvement in the local circulation can be effected.

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MSMS

FOREIGN BODIES IN THE ABDOMEN

(Continued from Page 631)

Lewison,[2,3] they could have been recognized preoperatively and perhaps many years sooner.

Summary

Two cases of intra-abdominal foreign bodies (gauze sponges) are reported, the first of twenty-eight years and the second of twenty-three years' duration.

References

1. Crossen, H. S., and Crossen, D. F.: Foreign Bodies Left in the Abdomen. St. Louis: C. V. Mosby Co., 1940.
2. Lewison, E. F.: Mod. Hosp., 58:67-68, (April) 1942.
3. Lewison, E. F.: Ann. Surg., 116:311-314, (Aug.) 1942.
4. Walker, M. A., and Coburn, C. E.: J. Kansas M. Soc., 42: 107, (March) 1941.

Editorial

DOCTORS FOR THOSE EMERGENCIES

THE PROGRAM of the twenty-first annual meeting of the National Conference on Medical Service, held in Chicago, February 8, 1948, was featured by a paper entitled, "Medical Public Relations Begin in the Doctor's Office" given by L. Fernald Foster, M.D., Bay City, secretary of the Michigan State Medical Society, which was very energetically received. This discussion started a series of editorials in the *Journal of the American Medical Association,* calling attention to certain failures of the profession in maintaining service of doctors for the public at all times, even though the doctors of a community are in the habit of taking a day off once a week. (Which is one day *less* than most workers take per week.)

It was suggested that registries be established where patients may secure doctors in case of emergency, when their own doctor is not available. This has been done in many communities, some of the doctors staying on call while the others are away. Moreover, medical men have been assigned to athletic contests so that care for injuries is immediately available. In other places, doctors have remained on call at the hospitals for night emergencies. Doctors have also been requested to stagger their days off, and to take especial precautions for patients whom they have reason to believe might need attention. In one city, local papers carry advertisements stating what doctor will be on duty. All these efforts are being made, but still the complaint comes that doctors do not answer calls, especially at night, and that they insist on seeing patients by appointment, then have their appointment dates filled for three to six weeks in advance. We have mentioned all these features which Dr. Foster stressed in his talk. It is gratifying to note that almost every State Medical Society journal has copied or quoted the American Medical Association editorial within the past few months.

When the American Medical Association release arrived, one of our newspapers called us to ask whether anything was being done locally in behalf of that anxious patient. We were pleased to report measures to meet the program.

These remarks are in the nature of inviting our attention to the needs of the patient when he is sick. He needs a doctor when he is ill—not two weeks later.

Our congratulations to a medical profession which is ever striving to render a better and more complete medical service. We are proud of our membership.

THE CORNELIAN CORNER

ONE OF THE PAPERS published in this issue presents a different approach to the problem of care for the not-normal person. The description of the Cornelian Corner is worthy of consideration, and gives promise of advance in psychiatry. It is a well-presented paper and has a great deal of merit. In evaluating the factors that enter into the personality make-up, no mention is made of what we like to speak of as differences in constitutional endowment. In other words, human beings to use the language of the street, also fall into the category of "there are different breeds of cats."

The Cornelian Corner argues that environmental factors largely outweigh constitutional endowments. They can undoubtedly influence them largely but constitutional endowment cannot be disregarded. With this thought in mind, we have asked the president of the Cornelian Corner to make a statement on that subject which is here presented in the following signed editorial.

HEREDITY

NO ONE can deny the presence of a constitutional factor in each individual. It is the present-day consensus, however, that environmental influences largely outweigh the constitutional endowments in the etiology of most mental disorders. According to Freud, who stressed the importance of heredity throughout his writings, the constitutional element only becomes an etiological factor in the development of mental illnesses when it is activated by the environmental influences. The most important of these influences are the psychological traumata of infancy and early childhood. Severe and persistent frustration of the instinctual satisfactions is an example. When the

(Continued on Page 642)

Welcome to New Members

During the month of April, a membership campaign was carried on in each of our fifty-five county medical societies. The response to this campaign was enthusiastic. A total of 260 new members has been certified. Some of our county societies boast 100 per cent membership. It is hoped that all county societies will approach this figure.

The advantages of membership in your county medical society are legion. I shall list only a few of them.

1. Automatic membership in the Michigan State Medical Society and the American Medical Association.
2. Opportunity for maintenance and constant improvement of your standards of medical practice for the protection of patients.
3. Increased protection against state and national legislation inimical to public interest and the advancement of medical science; and concerted efforts toward beneficial health measures.
4. Information and technical advice in medical-legal matters.
5. Closer association socially and scientifically with your colleagues in medicine who are interested in the same vital problems that you are.

To all new members, I extend a most hearty welcome and an urgent invitation to take an active part in the affairs of the Michigan State Medical Society. To those few Doctors of Medicine who, because of careless or questionable methods of practice, are not now priviliged to qualify for membership, I express a sincere wish that they may see fit to so change their ways as soon to become eligible for and active in organized medicine—one of the truly great organizations of this country.

P. L. Sedwick

President, Michigan State Medical Society

President's

Page

(Continued from Page 640)

psychological care of the child is quite satisfactory the constitutional element remains latent. In some children this inherited disposition is very strong while in others it is much weaker. This explains why one child will be seriously affected by the same experience which would produce only a minor disturbance in another. Freud was of the opinion that when psychotherapy is effective, or the patient recovers from his illness because of other reasons, the hereditary component in his personality again becomes latent. It is now generally accepted that too much has been attributed to the role of heredity and that insufficient attention has been paid to the acquired factors in mental disorders. This has been responsible for the therapeutic pessimism which has been so widespread. It is no longer a question of whether a given illness is hereditary or acquired but how much the constitutional factor has been responsible and how much the environmental influences have contributed to its development. In every instance it is a combination of both of these etiological factors, with emphasis on the environmental influences.

JAMES CLARK MALONEY

THE RED CROSS BLOOD PLASMA PROGRAM

WHEN it became known that the American Red Cross contemplated the establishment of a nation-wide blood procurement program, the Council of the Michigan State Medical Society appointed a committee to investigate the possibilities of applying such a program to the needs of the public, and to the hospitals of Michigan. On two occasions, this committee has met with Raymond F. Barnes, M.D., Director of Medical and Health Services for the Midwest Area of the American Red Cross, who was asked to discuss plans on a national basis. He recounted the Red Cross policies as follows:

"Except for one or two small community registries maintained by American Red Cross Chapters for the purpose of furnishing voluntary donors in emergency, the American Red Cross was not engaged in any blood donor program previous to World War II.

"When it became evident that this country would become involved in the war, there was no blood source available to the armed forces. It was evident that blood, at least plasma, would be needed in large quantities and this organization was asked to obtain it from the citizens of this country. The result was 13 and a quarter million pints.

"When hostilities ceased, the American Red Cross had become so nearly synonymous with blood procurement, that the question naturally arose as to whether the organization should continue to function in the blood procurement field for civilians as it had for the armed forces. Our central committee, the then governing board, as well as others who were responsible for the program, were hesitant at first to enter into a civilian program. The desire to serve was somewhat offset by numerous doubts. Would the people support it? Would the physicians of the country, national, state, and county medical groups want American Red Cross to assist? Could it be done without interfering with the programs of existing institutions or the established prerogatives of the practicing physicians? Could we have the wholehearted support of physicians and accredited hospitals? These and other questions caused hesitancy until early in 1947, when the American Red Cross laid them squarely before representatives of the American Medical Association, the American Hospital Association, the Catholic Hospital Association, the United States Public Health Service, and the Surgeons General with the request for advice as to procedure. A civilian blood program for American Red Cross was approved in principle by all of these groups and hence in June by our own Board of Governors. A national program was then decided upon and since that time Admiral Ross T. McIntyre has assumed its administration.

"American Red Cross Chapters have for some time previous to this decision, been encouraged to enter into community blood donor programs if requested by their local society and several have done so. In each case, only after full approval of their local medical, hospital, and public health groups. In each case, only in an assisting capacity with the medical group actually sponsoring the plan. Never in any case unless the local physicians desired such a plan and co-operated fully in it. No Chapter goes out ahead of its local medical group.

"In the national program, we have been assured that no community will be considered for a blood donor program unless the physicians of that community are wholeheartedly behind it and want it. It would be poor reasoning indeed to believe that any program could succeed nor would this organization attempt to make it succeed unless it was backed by the physicians and the hospitals of that community. The whole national plan is to assit the citizens, the doctors, and the hospitals."

At the present time, it is contemplated that such a program will be established in Ingham County, with the Michigan Department of Health Laboratory contracting to prepare the blood for use as plasma and other blood products, such as: serum albumin, immune serum globulin, antihemophiliac globulin, blood grouping serum, fibrin films and thrombin, red cell suspensions, and red cell paste and powder. A certain proportion will be reserved for use as whole blood transfusions.

(Continued on Page 672)

The Journal, M S M S

Historical Review

Many a doctor now living remembers receiving his first copy of THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY that September of 1902.

Few in the profession doubted the wisdom of the step made by the Michigan State Medical Society in starting its own publication. Fresh winds were blowing across America. The spirit of organization was riding that wind.

In Michigan this spirit had been early. It had resulted in the establishment of the county medical societies as branches of the MSMS, implementing the work of the parent organization.

The spirit needed flesh and a skeletal structure.

In the Beginning

Leartus Connor, M.D., recognized this when, at the height of the State Society meeting in Mt. Clemens in 1896, he announced that, in the following year, he intended to move the appointment of a committee "to consider the propriety and wisdom" of publishing the work of the Society in a medical journal controlled by the Society itself.

In his president's address before the Society, June 26-27, 1902, Doctor Connor suggested that a specific resolution be offered to direct the publication committee to issue transcripts in the form of a monthly journal to be known as THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY.

Dr. Connor had his groundwork well laid. Scores of medical men had helped him lay it, offering valuable suggestions since the idea had first glimmered six years before.

One of the key ideas was that of the naming of a committee of four members to serve as a board of publications. All matters relating to the expenditure of funds were to be referred to it; the JOURNAL's management was its responsibility.

So the new century saw the advent of a new publication—of, by and for the men and women of Michigan's medical profession. It has grown to be more than that. The important advances chronicled in its pages are watched by alert editors of newspapers and general publications even beyond the borders of the state.

The Presses Roll

Volume I, Number I was issued in September, 1902. It carried $2,500 worth of advertising—no mean item in assuring the continued life of the infant JOURNAL, and getting its message across to all members of the profession.

Knitting the structure of the county medical societies more closely was one of the first and primary objectives of THE JOURNAL. No one knew this better than the publication's first editor, Andrew P. Biddle, M.D., of Detroit.

Dr. Biddle was an editor in the Dr. Connor tradition. Like the man who had fathered THE JOURNAL, his work was a labor of love. He devoted every possible moment to it, aside from his duties as Secretary of the Society. His four years of constructive effort gave THE JOURNAL a flying start.

THE JOURNAL was published by a small printing house in Detroit in those formative years. During this period the publication of THE JOURNAL was placed under the direction of the Council, where it still remains.

Wilfrid Haughey, M.D., of Battle Creek came upon the scene in 1910, when he was named editor of THE JOURNAL and Secretary of the Michigan State Medical Society. He moved the publication offices to his own community, where it was printed for two years. During his third year THE JOURNAL was printed on the American Medical Association press in Chicago, the advertising policy and contracts having been altered to conform with the standards of the newly established Council on Pharmacy and Chemistry.

Following Dr. Benjamin R. Schenck of Detroit as editor, Dr. Haughey found his hands full. The publication was growing along with the organization it served. It was during Dr. Haughey's first three-year term as editor that No. 100 of THE JOURNAL rolled off the presses. At that time a "very special effort" was made to collect and publish pictures of all past presidents of the State Society, he recalls.

Editor Haughey, M.D.

Dr. Haughey's life has been anything but dull. A bachelor of arts at the University of Michigan; master of arts at University of Detroit; doctor of medicine at Wayne University and F.A.C.S., he has practiced in Battle Creek since his graduation in 1906. His first decade of service was in an office with his father, who was secretary of The Council of the Michigan State Medical Society during the initial ten years following its inception.

The Haugheys, father and son, were key men in the early years of the MSMS and THE JOURNAL.

And now we find Dr. Wilfrid Haughey again at the editorial helm of THE JOURNAL, a living tradition! For the present Michigan State Medical Society had its beginnings in 1866, when the senior Haughey began his career as secretary with the formation of the Council group.

Holding a medical reserve commission, the younger Dr. Haughey answered the call to the colors and served eighteen months in France during World War I. He served twenty-one years as a lieutenant-colonel in the reserves.

Holder of certificates of the Boards for both ophthalmology and otolaryngology, he is chief of the Eye, Ear, Nose and Throat Department of Battle Creek Sanitarium; has served as chief of staff for Leila Y. Post Montgomery Hospital for several years, and is currently on the staffs of both Leila and Community Hospitals.

For a period of about eleven years, Dr. Haughey served as secretary of the Calhoun County Medical Society. He was organizer of the Southwestern Michigan Tri-logical Society and occupied the offices of both secretary and president. He also became president of the Calhoun Society.

That's a full life by any standards—but it isn't all. Dr. Haughey was secretary of the MSMS when it was incorporated in 1910. As such he signed the charter. He signed the present charter in 1941.

Dr. Haughey's first term as editor of THE JOURNAL ended in 1913, when Dr. Frederick H. Warnshuis of Grand Rapids was elected editor and secretary of the Society. World War I interrupted Warnshuis' term abruptly. The work was taken over by Dr. Burton R. Corbus, who served about a year.

It was at this juncture that the offices of secretary and editor were separated. The jobs were too big for any one man.

Dr. James H. Dempster of Detroit stepped into THE JOURNAL editorial picture, followed in 1939 by Dr. Roy H. Holmes of Muskegon.

Once again a world war interrupted an editor's career. Dr. Holmes entered service—and Dr. Haughey stepped back into harness. He was serving as chairman of the publication committee at the time the Japanese attempted to promote their "Co-Prosperity Sphere," late in 1941. He was elected editor at the expiration of Dr. Holmes' term in January, 1943. He's been there ever since.

During this period covering the life of the official organ of the Michigan State Medical Society, THE JOURNAL has not missed a month of publication in forty-seven years—an unusual record. This June number is No. 568.

Journal Content

Virtually all of the papers presented at State Medical Society meetings have been printed in THE JOURNAL. Its scope has gone beyond that. Hundreds of papers offered at other sessions—county, district and special—have appeared in these pages. And there have been the numerous papers specially prepared for this publication by members of the profession desiring to impart their findings.

Every publication has its editorial policy. The policy of THE JOURNAL has consisted simply of

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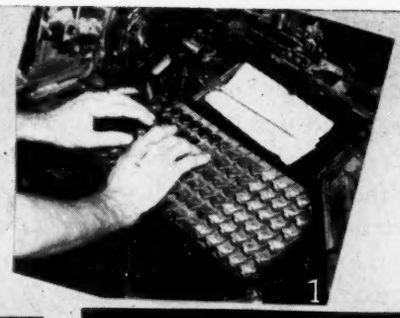
The life cycle of THE JOURNAL—from editor to reader—is shown at the right in a picture story of the major processes involved in the publication of each issue.

All written material to be used in THE JOURNAL is sent by the editor to the publishing company, where a copy editor checks grammar, punctuation, spelling, et cetera, and marks the copy with printing instructions. The material is then set in type by a linotype operator (1), after which his handiwork is checked against the original copy by proofreaders (2). Display type for each article's title is prepared with a special type-casting machine (3). When all material has been initialed "OK" by authors and editors, the type is made up into page-form to correspond with a "dummy" layout (4), and the pages of type are locked in large steel forms (5) to go on the presses. The cover for THE JOURNAL is printed on a small vertical press (6), while the forms for the magazine's pages are placed in huge horizontal flatbed presses and printed on large sheets of paper (7). In the bindery the large sheets are folded, again and again, by an automatic folding machine (8). The folded sections are then assembled in proper sequence, the cover is added, and the magazine is stitched together—all in a single continuous process on a special "gang stitcher" (9). Bundles of magazines then have their edges trimmed simultaneously by the razor-sharp knives of a trimming machine (10). The final task belongs to the mailing department (11), which sends to each reader his month's copy of THE JOURNAL.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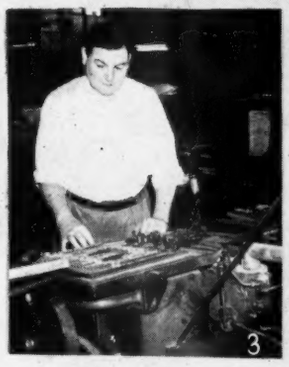
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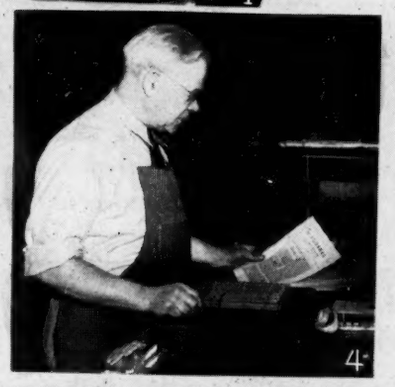
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The Journal

an attempt to translate to the members the ideals and objectives of the profession.

These ideals and objectives are high. Their standards, as dictated by the Council, shapes policy as regards editorial matter and advertising.

Under the latter heading, it is interesting to note that advertising lineage has jumped from 20⅞ pages in the January, 1933, issue, to an average of 53⅝ pages at the present time. Some state medical societies still refuse to allow inclusion of paid advertising. However, members of the Michigan State Medical Society, through their Council, decided some time ago that carefully screened advertising was distinctly worthwhile.

The advertising of local concerns are presented to our publication committee for acceptance or rejection. No product subject to review of the AMA Councils can be advertised in THE JOURNAL until Council acceptance is gained.

C M A B

The staff of the Cooperative Medical Advertising Bureau of the American Medical Association, Chicago, Illinois—from left to right, Harriet Lev, Lester A. Putzler, Eileen Murphy, D. Adelaide Kopp and Alfred J. Jackson, Director.

The Co-operative Medical Advertising Bureau—better known as the CMAB—of the American Medical Association, serves THE JOURNAL in securing a large volume of national advertising of reputable concerns. The Bureau not only sells the space, but gives a complete service in securing and reviewing copy, furnishing printing plates, in billing and collecting funds involved, and in transmitting revenue for all space cleared through its office.

Alfred J. Jackson, formerly with the advertising department of the AMA publications, assumed office as director of the CMAB, on January 1, 1946. For the JMSMS itself, L. Fernald Foster, M.D., is business manager; William J. Burns serves as advertising manager, and Harry Lipson is the local representative in the Detroit office.

And now, in 1948, we find 101 advertisers in the pages of THE JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY.

Production

The modernized JOURNAL—a far cry from the early issues—mounts up to 60,200 copies during the course of a year, requiring more than 22 tons of paper.

Perhaps you may be able to get a better picture of the production that goes into your publication if you will try to visualize the 288,000 sheets of paper (one year's editions) laid end to end to make a strip of paper 204 miles long.

The mechanical processes through which each month's edition of THE JOURNAL passes would hardly be recognized by the original editors, but, we are sure you will agree, the Bruce Publishing Company of Saint Paul, Minnesota, has mixed science and art to make this, your publication, a readable, artistic and informative organ. A special bouquet is due Miss Olive Seibert—the "contact man" of the publisher with the MSMS—who each month "puts THE JOURNAL to bed."

Back of this complex procedure, which continues day in and day out, month after month, that the record of Michigan's medical men may spread and endure, is the MSMS Publications Committee, composed of the following: Fred H. Drummond, M.D., Kawkawlin, chairman; Dean W. Myers, M.D., Ann Arbor; E. A. Oakes, M.D., Manistee; C. E. Umphrey, M.D., Detroit, and Wilfrid Haughey, M.D., Battle Creek.

These men, this publication, and the traditions of the Michigan State Medical Society had their humble beginnings in an obscure publication known as *The Michigan Journal of Homeopathy*, first published in Detroit on November 11, 1848—about the time gold was being discovered in California—by Drs. John Ellis and A. B. Thayer.

The publication died a few years later. The regular profession entered the field. Like the human race, it took many an attempt before a satisfactory product was evolved.

And, like the human race, the present JOURNAL is not perfection. It does attempt to maintain the high standards set by and for the protection of the membership of the Michigan State Medical Society, the advertisers and the medical profession. Criticisms and suggestions are always welcome.

MICHIGAN STATE MEDICAL SOCIETY

The 83rd Annual Session and Postgraduate Conference

O. O. Beck, M.D.
Birmingham
Council Chairman

P. L. Ledwidge, M.D.
Detroit
President

John S. DeTar, M.D.
Milan
Speaker

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, on September 20, 21, 22, 23, 24, 1948. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

P. L. Ledwidge, M.D.
President

O. O. Beck, M.D.
Council Chairman

J. S. DeTar, M.D.
Speaker

R. H. Baker, M.D.
Vice President

Attest:
L. Fernald Foster, M.D.
Secretary

L. Fernald Foster, M.D.
Bay City
Secretary

R. H. Baker, M.D.
Pontiac
Vice Speaker

TWO-DAY SESSION OF HOUSE OF DELEGATES, SEPTEMBER 20-21, 1948

The 1948 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 20 at 10:00 a.m. The business of the House of Delegates will be transacted in the Book-Cadillac Hotel, Detroit.

The House also will meet Monday at 8:00 p.m. and on Tuesday, September 21 at 10:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

Seating of Delegates

"Any Delegates-Elect not present to be seated at the hour of call of the First Session may be replaced by an accredited alternate next on the list as certified by the Secretary of the County Medical Society involved."—MSMS By-Laws, Chapter 3, Section 3.

Michigan State Medical Society

Past Presidents 1866-1947

1866—*C. M. Stockwell, Port Huron
1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchcock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
1883—*A. F. Whelan, Hillsdale
1884—*Donald Maclean, Detroit
1885—*E. P. Christian, Wyandotte
1886—*Charles Shepard, Grand Rapids
1887—*T. A. McGraw, Detroit
1888—*S. S. French, Battle Creek
1889—*G. E. Frothingham, Detroit
1890—*L. W. Bliss, Saginaw
1891—*George E. Ranney, Lansing
1892—*Charles J. Lundy (died before taking office)
*Gilbert V. Chamberlain, Flint, Acting President
1893—*Eugene Boise, Grand Rapids
1894—*Henry O. Walker, Detroit
1895—*Victor C. Vaughan, Ann Arbor
1896—*Hugh McColl, Lapeer
1897—*Joseph B. Griswold, Grand Rapids
1898—*Ernest L. Shurly, Detroit
1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson
1903—*Wm. F. Breakey, Ann Arbor
1904—*B. D. Harison, Sault Ste. Marie
1905—*David Inglis, Detroit
1906—*Charles B. Stockwell, Port Huron
1907—*Hermon Ostrander, Kalamazoo
1908—*A. F. Lawbaugh, Calumet
1909—*J. H. Carstens, Detroit
1910—*C. B. Burr, Flint
1911—*D. Emmett Welsh, Grand Rapids
1912—*Wm. H. Sawyer, Hillsdale
1913—*Guy L. Kiefer, Detroit
1914—*Reuben Peterson, Ann Arbor
1915—*A. W. Hornbogen, Marquette
1916—*Andrew P. Biddle, Detroit
1917—*Andrew P. Biddle, Detroit
1918— Arthur M. Hume, Owosso
1919—*Charles H. Baker, Bay City
1920—*Angus McLean, Detroit
1921—*Wm. J. Kay, Lapeer
1922—*W. T. Dodge, Big Rapids
1923—*Guy L. Connor, Detroit
1924—*C. C. Clancy, Port Huron
1925—*Cyrenus G. Darling, Ann Arbor
1926— J. B. Jackson, Kalamazoo
1927— Herbert E. Randall, Flint
1928— Louis J. Hirschman, Detroit
1929— J. D. Brook, Grandville
1930—*Ray C. Stone, Battle Creek
1931—*Carl F. Moll, Flint
1932— J. Milton Robb, Detroit
1933—*George LeFevre, Muskegon
1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936— Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938— Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943— C. R. Keyport, Grayling
1944— A. S. Brunk, Detroit
1945— R. S. Morrish, Flint
1946— Wm. A. Hyland, Grand Rapids

*Deceased.

MICHIGAN STATE MEDICAL SOCIETY

The 83rd Annual Session and Postgraduate Conference

Book-Cadillac Hotel, Detroit, September 22, 23, 24, 1948

INFORMATION

DETROIT WILL BE HOST TO MSMS IN SEPTEMBER

The Program of the General Assembly for the 83rd Annual Session and Postgraduate Conference of the Michigan State Medical Society lists guest speakers from all parts of the United States and Canada. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated postgraduate course in all phases of medicine and surgery for the busy practitioners of Michigan and neighboring states and the Province of Ontario, on September 22, 23, 24, 1948.

Registration, Tuesday afternoon through Friday afternoon, September 21-24, Fifth Floor, Book-Cadillac Hotel, Detroit.

No registration fee for AMA and Canadian MA members.

Admission by badge only.

Postgraduate Credits given to every MSMS member who attends MSMS Annual Session.

Seven General Assemblies—Thirteen Section Meetings—Twenty-two Discussion Conferences on September 22, 23, 24.

Public Meeting. The Third General Assembly, Wednesday, September 22, 8:30 p.m.—Officers' Night—will be open to the public. Invite your patients and friends to hear an internationally famous personage scheduled for this program.

Papers will begin and end on time. This scientific meeting will feature by-the-clock promptness and regularity.

MSMS House of Delegates convenes Monday, September 20 at 10:00 a.m., Book-Cadillac Hotel, Detroit; it will hold two meetings on Monday, September 20, at 10:00 a.m. and at 8:00 p.m.; also two meetings on Tuesday September 21, at 10:00 a.m. and at 8:00 p.m.

Eighty-three Technical Exhibits will contain much of interest and value. Intermissions to view the exhibits have been arranged.

Please register at every booth.

Douglas Donald, M.D., Detroit, is General Chairman of the Detroit Committee on Arrangements for the 1948 MSMS Annual Session and Postgraduate Conference.

Press Relations Committee for the scientific session: H. F. Dibble, M.D., Detroit, Chairman; W. A. Chipman, M.D., Detroit; L. T. Henderson, M.D., Detroit; R. A. Johnson, M.D., Detroit; J. J. Lightbody, M.D., Detroit; C. J. Smyth, M.D., Detroit.

Transportation—The Pere Marquette Streamliners from Grand Rapids to Detroit afford a convenient means of transportation to the MSMS Annual Session for hundreds of physicians in the central and southeastern parts of the State.

The Medical Assistants Conference is scheduled for Thursday, September 23, in the English Room, Book-Cadillac Hotel, Detroit, beginning at 7:00 p.m. The Medical Assistants group is composed of doctors' office secretaries and nurses.

The Alumni of Loyola University School of Medicine will gather at a dinner meeting Thursday, September 23, at the Book-Cadillac Hotel.

The Woman's Auxiliary to the Michigan State Medical Society will present an attractive social and business program at the Fort Shelby Hotel, Detroit, to which the wife of every MSMS member is cordially invited.

Members of **Michigan Medical Service** will meet in annual session Monday, September 20, 2:00 p.m., in The Grand Ballroom, Book-Cadillac Hotel, Detroit.

WHAT IT TAKES TO BE A DOCTOR OF MEDICINE

1. Four Years of High School
2. Two Years of College (including Physics, Chemistry, and Biology)
3. Four Years in Medical College
4. One Year's Internship in a Hospital
5. A knowledge of the Human Body: Its Normal Structures, Functions and Governing Laws
6. A Knowledge of All Common Diseases in Order to Know What Disease is Present
7. A Knowledge of Effective Remedial Agents: Ability to Apply the One Most Needed.

These Minimum Essentials Should Be Possessed by All Who Treat the Sick

House of Delegates

ORDER OF BUSINESS*

MONDAY, SEPTEMBER 20

English Room, Book-Cadillac Hotel, Detroit

10:00 a.m.—First Meeting

1. **Call to order by Speaker**
2. **Report of Committee on Credentials**
3. **Roll call**
4. **Appointment of Reference Committees**
   (1) On Officers' Reports
   (2) On Reports of the Council
   (3) On Reports of Standing Committees
   (4) On Reports of Special Committees
   (5) On Amendments to Constitution and By-Laws
   (6) On Resolutions
   (7) On Special Memberships
5. **Speaker's Address**—J. S. DeTar, M.D., Milan
6. **President's Address**—P. L. Ledwidge, M.D., Detroit
7. **President-Elect's Address**—E. F. Sladek, M.D., Traverse City
8. **Annual Report of the Council**—O. O. Beck, M.D., Birmingham, Chairman
9. **Report of Delegates to American Medical Association**—L. G. Christian, M.D., Lansing, Chairman
10. **Report of Commission on Health Care**—R. L. Pino, M.D., Detroit, Chairman
11. **Report of Special Committee on Revision of Constitution and By-Laws.**—T. K. Gruber, M.D., Eloise, Chairman
12. **Resolutions****
13. **Reports of Standing Committees**
    (a) Legislative Committee
    (b) Committee on Distribution of Medical Care
    (c) Medical Legal Committee
    (d) Preventive Medicine Committee
        Cancer
        Maternal Health
        Venereal Disease Control
        Tuberculosis Control
        Industrial Health
        Mental Hygiene
        Child Welfare
        Iodized Salt
        Heart and Degenerative Diseases
    (e) Committee on Postgraduate Medical Education
    (f) Committee on Public Relations (and sub-committees)
    (g) Committee on Ethics
14. **Reports of Special Committees**
    (a) Committee on Nurses' Training Schools
    (b) Scientific Radio Committee
    (c) Advisory Committee to Woman's Auxiliary
    (d) Scientific Work Committee (in Council's Report)
    (e) Beaumont Memorial Committee
    (f) State Interprofessional Committee
    (g) Rheumatic Fever Control Committee
    (h) Committee on State Veterans Affairs
    (i) Committee on Uniform Fee Schedule for Governmental Agencies
    (j) Committee on Rural Health
    (k) Committee on Michigan High School Athletic Accident Benefit Fund
    (l) Committee on National Emergency Medical Service
    (m) Committee on Red Cross Blood Bank

MONDAY, SEPTEMBER 20

Grand Ballroom, Book-Cadillac Hotel, Detroit

8:00 p.m.—Second Meeting

15. **Supplementary Report of Committee on Credentials**
16. **Roll Call**
17. **Unfinished Business**
18. **New Business†**
19. **Reports of Reference Committees**
    (a) On Officers Reports
    (b) On Reports of the Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Amendments to Constitution and By-Laws
    (f) On Resolutions
    (g) On Special Memberships

TUESDAY, SEPTEMBER 21

Grand Ballroom, Book-Cadillac Hotel, Detroit

10:00 a.m.—Third Meeting

20. **Supplementary Report of Committee on Credentials**
21. **Roll call**
22. **Unfinished Business**
23. **New Business**
24. **Supplementary Reports of Reference Committees**
    (a) On Officers Reports
    (b) On Reports of the Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Amendments to Constitution and By-Laws
    (f) On Resolutions
    (g) On Special Memberships

*See the Constitution, Article IV, and the By-Laws, Chapter 3 on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

†All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

TUESDAY, SEPTEMBER 21

Grand Ballroom, Book-Cadillac Hotel, Detroit

8:00 p.m.—Fourth Meeting

25. Supplementary Report of Committee on Credentials

26. Roll Call

27. Unfinished Business

28. Supplementary Report of the Council

29. Supplementary Report of Reference Committees

30. Elections

(a) Councilors

11th District—R. H. Holmes, M.D., Muskegon—Incumbent

12th District—A. H. Miller, M.D., Gladstone, Incumbent

13th District—W. H. Huron, M.D., Iron Mountain—Incumbent

(b) Delegate to American Medical Association

W. D. Barrett, M.D., Detroit—Incumbent

T. K. Gruber, M.D., Eloise—Incumbent

C. R. Keyport, M.D., Grayling—Incumbent

(c) Alternate Delegates to American Medical Association

R. L. Novy, M.D., Detroit—Incumbent

R. H. Denham, M.D., Grand Rapids—Incumbent

C. I. Owen, M.D., Detroit—Incumbent

(d) President—Elect

(e) Speaker of House of Delegates

(f) Vice Speaker of House of Delegates

Adjournment

DELEGATES TO MSMS HOUSE OF DELEGATES, 1948

Names of Alternates appear in Italics

Officers

J. S. DeTar, M.D.
Milan, Speaker

R. H. Baker, M.D.
Pontiac, Vice Speaker

L. Fernald Foster, M.D.
Bay City, Secretary

W. A. Hyland, M.D.
Grand Rapids, Immediate Past President

Allegan

L. F. Brown, M.D., Otsego
E. B. Johnson, M.D., Allegan

Alpena-Alcona-Presque Isle

W. E. Nesbitt, M.D., Alpena
F. J. O'Donnell, M.D., Alpena

Barry

A. B. Gwinn, M.D., Hastings
C. A. E. Lund, M.D., Middleville

Bay-Arenac-Iosco

W. S. Stinson, M.D., 101 W. John, Bay City
A. D. Allen, M.D., 101 W. John, Bay City
A. H. Jacoby, M.D., 2202 Ninth, Bay City
N. R. Moore, M.D., 601 Fifth Ave., Bay City

Berrien

D. W. Thorup, M.D., Benton Harbor
J. G. Ruth, M.D., Benton Harbor

Branch

R. L. Wade, M.D., Coldwater
H. J. Meier, M.D., Coldwater

Calhoun

B. G. Holtom, M.D., 815 Security Bank Bldg., Battle Creek
G. W. Slagle, M.D., 1206 Security Tower, Battle Creek
C. G. Wencke, M.D., 1015 Security Bank Bldg., Battle Creek
H. C. Hansen, M.D., 417 Post Bldg., Battle Creek

Cass

S. L. Loupee, M.D., Dowagiac
J. H. Hickman, M.D., Dowagiac

Chippewa-Mackinac

B. T. Montgomery, M.D., Sault Ste. Marie
D. C. Howe, M.D., Sault Ste. Marie

Clinton

T. Y. Ho, M.D., St. Johns
G. E. Wahl, M.D., St. Johns

Delta-Schoolcraft

W. A. LeMire, M.D., Escanaba
A. H. Miller, M.D., Gladstone

Dickinson-Iron

D. R. Smith, M.D., Iron Mountain
L. E. Irvine, M.D., Iron River

Eaton

G. C. Stucky, M.D., Charlotte
P. H. Engle, M.D., Olivet

Genesee

A. H. Kretchmar, M.D., 608 First National Bldg., Flint
A. N. Thompson, M.D., Mott Foundation Bldg., Flint
A. C. Pfeifer, M.D., Mt. Morris
J. E. Livesay, M.D., 619 Mott Foundation Bldg., Flint
G. E. Anthony, M.D., 1015 Detroit, Flint
C. W. Stroup, M.D., 2002 E. Court, Flint
V. H. Morrissey, M.D., 101 Stockdale, Flint
F. W. Baske, M.D., 1217 Mott Foundation Bldg., Flint

Gogebic

A. C. Gorrilla, M.D., Ironwood
M. J. Lieberthal, M.D., Ironwood

Grand Traverse-Leelanau-Benzie

D. G. Pike, M.D., Traverse City
C. E. Lemen, M.D., Traverse City

Gratiot-Isabella-Clare

M. G. Becker, M.D., Edmore
E. S. Oldham, M.D., Breckenridge

Hillsdale

L. W. Day, M.D., Jonesville
O. G. MacFarland, M.D., North Adams

Houghton-Baraga-Keweenaw

T. P. Wickliffe, M.D., Calumet
A. M. Roche, M.D., Calumet

Huron

C. W. Oakes, M.D., Harbor Beach
W. B. Holdship, M.D., Ubly

Ingham

L. G. Christian, M.D., 108 E. St. Joseph, Lansing
H. W. Wiley, M.D., 300 W. Ottawa, Lansing
R. S. Breakey, M.D., 1211 Bank of Lansing Bldg., Lansing
John Wellman, M.D., 301 Seymour, Lansing
Milton Shaw, M.D., 320 Townsend, Lansing
J. S. Rozan, M.D., 511 Bank of Lansing Bldg., Lansing

Ionia-Montcalm

W. L. Bird, M.D., Greenville
E. S. Socha, M.D., Ionia

Jackson
J. J. O'Meara, M.D., Jackson
C. S. Clarke, M.D., Jackson
J. D. Van Schoick, M.D., Hanover
C. R. Dengler, M.D., Jackson

Kalamazoo
L. W. Gerstner, M.D., Kalamazoo
R. J. Armstrong, M.D., Kalamazoo
W. A. Scott, M.D., Kalamazoo
M. D. Verhage, M.D., Kalamazoo

Kent
W. B. Mitchell, M.D., Medical Arts Bldg., Grand Rapids
R. H. Denham, M.D., Metz Bldg., Grand Rapids
A. V. Wenger, M.D., 302 Lorraine Bldg., Grand Rapids
Andrew Van Solkema, M.D., 953 E. Fulton, Grand Rapids
L. C. Carpenter, M.D., Metz Bldg., Grand Rapids
G. W. DeBoer, M.D., 516 Medical Arts Bldg., Grand Rapids
Torrance Reed, M.D., Ashton Bldg., Grand Rapids
W. R. Torgerson, M.D., Metz Bldg., Grand Rapids
S. L. Moleski, M.D., 528 Medical Arts Bldg., Grand Rapids
C. E. Farber, M.D., 408 Metz Bldg., Grand Rapids
L. O. Grant, M.D., 420 Medical Arts Bldg., Grand Rapids
R. S. VanBree, M.D., 204 Lorraine Bldg., Grand Rapids

Lapeer
D. J. O'Brien, M.D., Lapeer
H. M. Best, M.D., Lapeer

Lenawee
P. L. Miller, M.D., Adrian
W. H. Hewes, M.D., Adrian

Livingston
H. G. Huntington, M.D., Howell
R. W. Lieber, M.D., Howell

Luce
F. R. Koss, M.D., Newberry
E. H. Campbell, M.D., Newberry

Macomb
D. B. Wiley, M.D., 4692 Van Dyke, Utica
E. G. Siegfried, M.D., New Haven

Manistee
E. B. Miller, M.D., Manistee
J. F. Konopa, M.D., Manistee

Marquette-Alger
R. A. Burke, M.D., Negaunee
L. W. Howe, M.D., Marquette

Mason
N. M. Comodo, Ludington

Mecosta-Osceola-Lake
T. B. Treynor, M.D., Big Rapids
P. B. Kilmer, M.D., Reed City

Medical Society of North Central Counties
(Otsego—Montmorency—Crawford—Oscoda—Roscommon—Ogemaw)
R. C. Peckham, M.D., Gaylord
C. G. Clippert, M.D., Grayling

Menominee
W. S. Jones, M.D., Menominee

Midland
R. S. Ballmer, M.D., Midland
H. L. Gordon, M.D., Midland

Monroe
T. A. McDonald, M.D., Monroe
J. P. Flanders, M.D., Monroe

Muskegon
L. E. Holly, M.D., 876 N. Second, Muskegon
T. J. Kane, M.D., 179 Strong Ave., Muskegon
Louis Le Fevre, M.D., 450 W. Western, Muskegon
R. D. Risk, M.D., 1160 Ransom, Muskegon

Newaygo
B. L. Masters, M.D., Fremont
T. R. Deur, M.D., Grant

Northern Michigan
(Antrim—Charlevoix—Emmet—Cheboygan)
J. R. Rodger, M.D., Bellaire
G. B. Saltonstall, M.D., Charlevoix

Oakland
H. A. Furlong, M.D., 932 Riker Bldg., Pontiac
C. R. Gatley, M.D., 97 N. Perry, Pontiac
T. H. Pauli, M.D., 206 Riker Bldg., Pontiac
F. J. Kemp, M.D., 1115 Peoples State Bank Bldg., Pontiac
J. M. Markley, M.D., 1026 Riker Bldg., Pontiac

Oceana
W. G. Robinson, M.D., Hart

Ontonagon
W. F. Strong, M.D., Ontonagon
H. B. Hogue, M.D., Ewen

Ottawa
D. C. Bloemendaal, M.D., Zeeland
K. N. Wells, M.D., Spring Lake

Saginaw
C. E. Toshach, M.D., 330 S. Jefferson, Saginaw
L. C. Harvie, M.D., 405 Wiechmann Bldg., Saginaw
H. G. Kleekamp, M.D., 1005 Gratiot Ave., Saginaw
Stuart Yntema, M.D., 333 S. Jefferson, Saginaw

Sanilac
R. K. Hart, M.D., Croswell
N. J. Ellis, M.D., Croswell

Shiawassee
C. L. Weston, M.D., Owosso
J. F. Sahlmark, M.D., Owosso

St. Clair
George Waters, M.D., Port Huron
W. H. Boughner, M.D., Algonac

St. Joseph
R. A. Springer, M.D., Centerville
R. J. Fortner, M.D., Three Rivers

Tuscola
L. L. Savage, M.D., Caro
F. J. Gugino, M.D., Reese

Van Buren
W. R. Young, M.D., Lawton
E. H. Terwilliger, M.D., South Haven

Washtenaw
H. H. Riecker, M.D., St. Joseph Mercy Hospital, Ann Arbor
B. M. Harris, M.D., 220 Pearl, Ypsilanti
P. S. Barker, M.D., University Hospital, Ann Arbor
O. K. Engelke, M.D., 720 E. Catherine, Ann Arbor
R. W. Teed, M.D., 215 S. Main, Ann Arbor
A. M. Waldron, M.D., 324 S. State, Ann Arbor
R. I. Seime, M.D., 302 W. Cross, Ypsilanti
H. A. Miller, M.D., 300 E. Henry, Saline

Wayne
Douglas Donald, M.D., 7815 E. Jefferson, Detroit
J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
G. T. McKean, M.D., 1515 David Whitney Bldg., Detroit
W. B. Harm, M.D., 5884 W. Vernor Highway, Detroit
Arch Walls, M.D., 12065 Wyoming, Detroit
E. D. Spalding, M.D., 320 Professional Bldg., Detroit
C. L. Candler, M.D., 2006 David Broderick Tower, Detroit
W. J. Stapleton, Jr., M.D., 641 David Whitney Bldg., Detroit
E. C. Texter, M.D., 7457 Gratiot, Detroit
F. A. Weiser, M.D., Grace Hospital, Detroit
G. C. Penberthy, M.D., 1515 David Whitney Bldg., Detroit
R. L. Novy, M.D., 858 Fisher Bldg., Detroit
Charles Kennedy, M.D., 10 Peterboro, Detroit
W. D. Barrett, M.D., 311 David Whitney Bldg., Detroit
T. K. Gruber, M.D., Wayne County General Hospital, Eloise
William Bromme, M.D., 318 Professional Bldg,, Detroit
Richard McKean, M.D., 1515 David Whitney Bldg., Detroit

C. J. Barone, M.D., 51 Eason, Highland Park
D. C. Beaver, M.D., Woman's Hospital, Detroit
E. H. Fenton, M.D., 15125 Grand River, Detroit
L. T. Henderson, M.D., 13038 E. Jefferson, Detroit
W. W. Babcock, M.D., 686 Fisher Bldg., Detroit
W. J. Cassidy, M.D., 1737 David Whitney Bldg., Detroit
E. G. Krieg, M.D., 1842 David Whitney Bldg., Detroit
E. A. Osius, M.D., 901 David Whitney Bldg., Detroit
W. S. Reveno, M.D., 968 Fisher Bldg., Detroit
C. I. Owen, M.D., Grace Hospital, Detroit
M. A. Darling, M.D., 673 Fisher Bldg., Detroit
H. J. Kullman, M.D., Veterans' Administration Hospital, Dearborn
A. E. Catherwood, M.D., 1337 David Whitney Bldg.,
S. W. Insley, M.D., 1202 Maccabees Bldg., Detroit
R. H. Pino, M.D., David Whitney Bldg., Detroit
L. W. Hull, M.D., 1701 David Whitney Bldg., Detroit
E. D. King, M.D., 5455 W. Vernor Highway, Detroit
B. H. Douglas, M.D., 334 Bates, Detroit
C. K. Hasley, M.D., 1429 David Whitney Bldg., Detroit
L. J. Bailey, M.D., 501 Professional Bldg., Detroit
L. J. Morand, M.D., 641 David Whitney Bldg., Detroit
H. F. Raynor, M.D., 1340 Maccabees Bldg., Detroit
J. E. Webster, M.D., 840 David Whitney Bldg., Detroit
A. V. Forrester, M.D., 18950 Woodward, Detroit
W. F. Seeley, M.D., 1807 David Whitney Bldg., Detroit
F. G. Buesser, M.D., 1515 Devid Whitney Bldg., Detroit
C. E. Lemmon, M.D., 1337 David Whitney Bldg., Detroit
H. B. Fenech, M.D., 324 Professional Bldg., Detroit
H. L. Morris, M.D., 1069 Fisher Bldg., Detroit
R. J. Schneck, M.D., 641 David Whitney Bldg., Detroit
R. A. Johnson, M.D., 7815 E. Jefferson, Detroit
L. J. Gariepy, M.D., 16401 Grand River, Detroit
M. H. Miller, M.D., 8120 W. McNichols Rd., Detroit
D. C. Somers, M.D., 760 Fisher Bldg., Detroit
R. Q. DeTomasi, M.D., 2642 Arndt, Detroit
W. L. Brosius, M.D., 2342 Leslie, Detroit
E. F. Dittmer, M.D., 14320 E. Jefferson, Detroit
R. V. Walker, M.D., 1255 David Whitney Bldg., Detroit
J. A. Kasper, M.D., Herman Kiefer Hospital, Detroit
L. A. Pratt, M.D., 2206 David Broderick Tower, Detroit
L. S. Fallis, M.D., Henry Ford Hospital, Detroit
P. J. Waltz, M.D., 16127 Woodward Ave., Detroit
R. C. Connelly, M.D., 1709 David Whitney Bldg., Detroit
H. L. Stern, M.D., 15826 James Couzens Highway, Detroit
E. C. Long, M.D., 2626 Rochester, Detroit
E. H. Lauppe, M.D., 1650 David Whitney Bldg., Detroit
S. M. Gillespie, M.D., 1101 Haigh, Detroit
J. E. Croushore, M.D., 573 Fisher Bldg., Detroit
C. F. Brunk, M.D., 7815 E. Jefferson, Detroit
D. I. Sugar, M.D., 1108 Stroh Bldg., Detroit
H. L. Clark, M.D., 634 Maccabees Bldg., Detroit
M. M. Frazer, M.D., 812 Kales Bldg., Detroit
L. J. Gravelle, M.D., 1101 David Whitney Bldg., Detroit
W. G. Reid, M.D., 974 Fisher Bldg., Detroit
D. H. Kaump, M.D., Providence Hospital, Detroit
J. K. Bell, M.D., 1654 First National Bldg., Detroit
G. C. Thosteson, M.D., 1139 David Whitney Bldg., Detroit
C. S. Ratigan, M.D., 22276 Garrison, Detroit
R. H. Bookmyer, M.D., 17198 Oak Dr., Detroit
L. B. Young, M.D., 857 Fisher Bldg., Detroit
C. R. Defever, M.D., 15124 Kircheval, Detroit
E. D. Rothman, M.D., 722 Maccabees Bldg., Detroit
C. E. Simpson, M.D., 1210 Kales Bldg., Detroit
T. G. Amos, M.D., 201 Curtis Bldg., Detroit
V. N. Butler, M.D., 28 W. Adams, Detroit
J. A. Witter, M.D., 344 Glendale, Detroit
A. E. Schiller, M.D., 2008 David Broderick Tower, Detroit

Wexford-Missaukee
L. E. Showalter, M.D., 400 E. Cass, Cadillac
C. E. Merritt, M.D., Manton

REFERENCE COMMITTEES, HOUSE OF DELEGATES, 1948

(All meetings of Reference Committees will be held in the Book-Cadillac Hotel, Detroit)

Credentials Committee

J. J. O'Meara, M.D., Jackson, *Chairman*
L. J. Bailey, M.D., Detroit — W. B. Harm, M.D., Detroit

Officers Reports
Parlor F

D. R. Smith, M.D., Iron Mountain, *Chairman*
R. J. Armstrong, M.D., Kalamazoo — A. H. Kretchmar, M.D., Flint
C. W. Oakes, M.D., Harbor Beach — C. L. Candler, M.D., Detroit
W. W. Babcock, M. D., Detroit — L. L. Savage, M.D., Caro

Reports of The Council
Parlor F

C. L. Weston, M.D., Owosso, *Chairman*
R. S. Ballmer, M.D., Midland — J. R. Rodger, M.D., Bellaire
E. A. Osius, M.D., Detroit — J. E. Webster, M.D., Detroit
C. I. Owen, M.D., Detroit — A. V. Wenger, M.D., Grand Rapids

Reports of Standing Committees
Parlor G

E. G. Kreig, M.D., Detroit, *Chairman*
O. K. Engelke, M.D., Ann Arbor — F. R. Koss, M.D., Newberry
L. T. Henderson, M.D., Detroit — A. N. Thompson, M.D., Flint
W. S. Jones, M.D., Menominee — F. A. Weiser, M.D., Detroit

Reports of Special Committees
Parlor G

G. C. Stucky, M.D., Charlotte, *Chairman*
D. C. Beaver, M.D., Detroit — B. T. Montgomery, M.D., Sault Ste. Marie
R. H. Denham, M.D., Grand Rapids — L. W. Hull, M.D., Detroit
L. W. Gerstner, M.D., Kalamazoo — W. S. Stinson, M.D., Bay City

Press Relations Committee
Parlor H

H. F. Dibble, M.D., Detroit, *Chairman*
R. H. Baker, M.D., Pontiac — Douglas Donald, M.D., Detroit
L. Fernald Foster, M.D., Bay City

Amendments to Constitution and By-Laws
Parlor I

E. D. Spalding, M.D., Detroit, *Chairman*
L. W. Day, M.D., Jonesville — L. E. Holly, M.D., Muskegon
H. A. Furlong, M.D., Pontiac — W. S. Reveno, M.D., Detroit
T. K. Gruber, M.D., Eloise — W. F. Strong, M.D., Ontonagon

Resolutions
Parlor J

William Bromme, M.D., Detroit, *Chairman*
L. C. Carpenter, M.D., Grand Rapids — H. J. Kullman, M.D., Dearborn
E. H. Fenton, M.D., Detroit — G. T. McKean, M.D., Detroit
B. M. Harris, M.D., Ypsilanti — W. E. Nesbitt, M.D., Alpena

Special Memberships
Parlor K

J. J. Lightbody, M.D., Detroit, *Chairman*
L. C. Harvie, M.D., Saginaw — E. C. Texter, M.D., Detroit
J. E. Livesay, M.D., Flint — D. B. Wiley, M.D., Utica

MSMS STENOGRAPHERS' ROOM
Suite 500

GENERAL ASSEMBLIES

All General Assemblies will be held in the Grand Ballroom of the Book-Cadillac Hotel, Detroit.

First General Assembly

WEDNESDAY, SEPTEMBER 22 *(morning)*

A.M.

9:00 *F. H. Lahey, M.D., Boston*
Director of Lahey Clinic; Surgeon-in-Chief to the New England Baptist Hospital and the New England Deaconess Hospital
"Present Status of Treatment of Thyroid Disease"
Dermatologist

9:30 *I. S. Wright, M.D., New York City*
Associate Professor of Clinical Medicine Cornell University Medical College; Chief of the Vascular Section of the Department of Medicine, Cornell University Medical College and New York Hospital; Civilian Consultant in Medicine to the Surgeon General—U. S. Army
"The Modern Treatment for Myocardial Infarctions Including the Use of Anticoagulants"

11:00 *S. C. Cullen, M.D., Iowa City, Iowa*
Associate Professor of Surgery, Chairman Division of Anesthesiology, The State University of Iowa.
"The Rational Application of Sedative Drugs"

11:30 *A. R. Woodburne, M.D., Denver, Colorado*
Dermatologist
"Radiation Effects on the Skin and Their Treatment"

Second General Assembly

WEDNESDAY, SEPTEMBER 22 *(afternoon)*

P.M.

1:30 *A. L. Gesell, M.D., New Haven, Connecticut*
Director of the Clinic of Child Development, Yale University; Professor of Child Hygiene, Yale School of Medicine; Attending Physician at New Haven Hospital
"The Periodic Diagnosis of Infant Development. Its Significance in a Preventive Program of Clinical Supervision both for normal and handicapped children."

2:00 *J. E. Dees, M.D., Durham, N. C.*
Assistant Professor of Urology, Duke University Medical School
"Urological Aspects of Abdominal Pain"

2:30 *M. E. Davis, M.D., Chicago*
Joseph Bolivar De Lee, M.D., Chicago
Professor of Obstetrics and Gynecology, University of Chicago and Chicago Lying-in Hospital
"The Management of the Placental Stage in the Prevention of Postpartum Hemorrhage"

4:00 *Philip Thorek, M.D., Chicago*
Assistant Clinical Professor of Surgery, University of Illinois College of Medicine; Associate Professor, Cook County Graduate School of Medicine; Associate Attending Surgeon, Cook County Hospital; Attending Surgeon, Alexian Brothers' Hospital and American Hospital; Diplomate of the American Board of Surgery; Fellow of the American College of Surgeons.
"Acute Abdominal Emergencies."

4:30 *Waltman Walters, M.D., Rochester, Minnesota*
Professor of Surgery, Mayo Foundation; Head of Section in Surgery, Mayo Clinic.
"Present Status of the Treatment of Peptic Ulcer."

Third General Assembly

WEDNESDAY, SEPTEMBER 22 *(evening)*

PUBLIC MEETING

P.M.

8:30 *Officers' Night*
Presidential Address and induction of new President
Biddle Oration

Fourth General Assembly

THURSDAY, SEPTEMBER 23 *(morning)*

A.M.

9:00 *R. W. TeLinde, M.D., Baltimore*
"Present Day Indications for Hysterectomy"

9:30 *T. C. Galloway, M.D., Evanston, Illinois*
Associate Professor of Otolaryngology, Northwestern University Medical School, Attending Otolaryngologist, Evanston Hospital, Attending Otolaryngologist, Cook County Hospital
"Secretional Respiratory Obstruction and Bulbar Poliomyelitis"

11:00 *R. L. J. Kennedy, M.D., Rochester, Minnesota*
B.S., M.B., M.S. in Pediatrics; Professor of Pediatrics, Mayo Foundation, University of Minnesota and Head of the Section on Pediatrics, Mayo Clinic.
"Significance of Blood in the Stools in Infants and Children"

11:30 *Haven Emerson, M.D., New York City*
Member of Board of Health of the City of New York; Emeritus Professor of Public Health Practice, Columbia University; Visiting Lecturer in Public Health, University of Michigan.
"The Application of Preventive Medicine Through Local Government"

Fifth General Assembly

THURSDAY, SEPTEMBER 23 *(afternoon)*

P.M.

1:30 *J. B. Barnwell, M.D., Washington, D. C.*
Chief, Tuberculosis Division, Veterans Administration
"Results of a co-operative study on the effects of Streptomycin"

2:00 *L. R. Dragstedt, M.D., Chicago*
Professor of Surgery and Chairman of Department of Surgery at University of Chicago and Attending Surgeon at Albert Merritt Billings Hospital
"Gastric Vagotomy in the Treatment of Peptic Ulcer"

2:30 *F. H. Adler, M.D., Philadelphia*
Professor of Ophthalmology, University of Pennsylvania; Consulting Surgeon at Wills Hospital; Member American Ophthalmological Society and American Academy of Ophthalmology and Otolaryngology
"Thyrotropic Exophthalmos from the Viewpoint of the Ophthalmologist"

4:00 *E. G. Waters, M.D., Jersey City, N. J.*
Division Chief of Obstetrics at Margaret Hague Maternity Hospital, Assistant Professor of Clinical Obstetrics and Gynecology, Columbia University
"Labor Experiences of Elderly Primigravida" (Based upon 56,392 deliveries)

4:30 *R. R. Linton, M.D., Brookline, Mass.*
"Postoperative Thrombophlebitis"

State Society Night

THURSDAY, SEPTEMBER 23 *(evening)*

P.M.

10:00 Dancing for MSMS members and their ladies. Grand Ballroom, Book-Cadillac Hotel, Detroit

Sixth General Assembly

FRIDAY, SEPTEMBER 24 *(morning)*

A.M.

9:00 *T. G. Randolph, M.D., Chicago*
Instructor in Department of Internal Medicine, Northwestern University Medical School
"How Do You Know Your Patient is Food Sensitive?"

9:30 *D. M. Pillsbury, M.D., Philadelphia*
Professor, Department of Dermatology and Syphilology, University Hospital, University of Pennsylvania
"The Treatment of Syphilis"

11:00 *W. J. Reich, M.D., Chicago*
Attending Gynecologist at Fantus Clinics of Cook County Hospital; Professor, Gynecology, Cook County Graduate School; Attending Gynecologist at Fox River T.B. Sanitarium; Consulting Gynecologist, Hazelcrest General Hospital
"Practical Office Procedure in Gynecology"

11:30 *C. C. Burlingame, M.D., Hartford, Connecticut*
Psychiatrist-in-Chief of the Institute of Living (Neuro-Psychiatric Institute of the Hartford Retreat); Associate in Psychiatry of Columbia University; Editor "Digest of Neurology and Psychiatry"
"Good Psychiatry is Good Medicine"

Seventh General Assembly

FRIDAY, SEPTEMBER 24 *(afternoon)*

P.M.

1:30 *Alexander Brunschwig, M.D., New York City*
Attending Surgeon, Memorial Hospital and Professor of Clinical Surgery, Cornell University Medical College
"Radical Surgery for Advanced Pelvic Cancer"

2:00 *M. D. Leigh, M.D., Vancouver, B.C., Canada*
Director Department of Anesthesiology, The Vancouver General Hospital
"Pediatric Anesthesiology"

2:30 *S. P. Reimann, M.D., Philadelphia*
Director of The Lankenau Hospital Research Institute, and the Institute for Cancer Research in Philadelphia; Associate Professor of Surgical Pathology, Graduate School of Medicine, University of Pennsylvania; Professor of Oncology, Hahnemann Medical College and Hospital
"Attempts at the Chemotherapy of Cancer"

4:00 *G. H. Pratt, M.D., New York City*
Assistant Clinical Professor of Surgery New York Postgraduate Medical School and College; Chief of Vascular Surgical Clinic, New York Postgraduate Hospital; Attending Surgeon, St. Clare's Hospital
"Recent Advances in the Surgical Treatment of Peripheral Arterial Disease"

4:30 *W. L. Palmer, M.D., Chicago*
Professor Medicine, University of Chicago
"Nervous Indigestion"

General Assemblies end at 5:00 p.m.

Have You Made Your

HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY

83rd Annual Session

Detroit, September 22, 23, 24, 1948

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to E. C. Texter, M.D., Chairman of Housing Committee, c/ 1005 Stroh Bldg., Detroit Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

E. C. Texter, M.D., Chairman of Housing Committee,
Michigan State Medical Society Annual Session,
c/o 1005 Stroh Bldg., Detroit, Michigan.

Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for .....persons

.....Twin Bedded Room(s) for .....persons

Arriving September .....hour.....A.M.....P.M.

Leaving September .....hour.....A.M.....P.M.

(Names and addresses of all applicants including person making reservation).

Name Address City State

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Date ..... Signature .....

Address ..... City.....

SECTION MEETINGS

Tentative Program

WEDNESDAY, SEPTEMBER 22
(12:00 noon to 1:30 p.m.)
(luncheon meetings)

1. **Dermatology**
   A. R. Woodburne, M.D., Denver, Colorado
   "Nodular Diseases of the Extremities"
2. **Anesthesia**
   S. C. Cullen, M.D., Iowa City, Iowa
   "Nitrous Oxide—Curare Anesthesia for Major Surgery"
3. **Urology**
   J. E. Dees, M.D., Durham, N. C.
   "Unexplained Renal Hematuria"
4. **Gynecology-Obstetrics**
   M. E. Davis, M.D., Chicago
   "Abdominal versus Vaginal Delivery"

THURSDAY, SEPTEMBER 23
(12:00 noon to 1:30 p.m.)
(luncheon meetings)

5. **Pediatrics**
   R. L. J. Kennedy, M.D., Rochester, Minnesota
   "Xanthomatosis—Christian-Schuller's Denasi—and Eosinophilic Granuloma"
6. **Surgery**
   R. R. Linton, M.D., Brookline, Mass.
   "Portal Hypertension—Treatment by Venous Shunts"
7. **Otolaryngology**
   T. C. Galloway, M.D., Evanston, Ill.
   "Anoxia and Secondary Effects of Respiratory Obstruction"
8. **Ophthalmology**
   F. H. Adler, M.D., Philadelphia
   "The Choice of Operation in Paralysis of the Ocular Muscles"
9. **Public Health and Preventive Medicine**
   Haven Emerson, M.D., New York City
   "Distinctions Between Personal and Administrative Medicine"

FRIDAY, SEPTEMBER 24
(12:00 noon to 1:30 p.m.)
(luncheon meetings)

10. **Pathology**
    S. P. Reimann, M.D., Philadelphia
    "Certain Facts of Experimental Embryology and their Relation to Pathological Anatomy"
11. **Medicine**
    H. J. Kullman, M.D., Dearborn
    Chief of Medical Service, Veterans Administration Hospital, Dearborn, Mich., and Assistant Professor of Clinical Medicine, Wayne University College of Medicine, Detroit, Mich.
    "Amebiasis and its Complications, Diagnosis and Treatment"
12. **General Practice**
    W. J. Reich, M.D., Chicago
    "The Evaluation of Post-Menopausal Bleeding"
13. **Nervous and Mental Diseases**
    C. C. Burlingame, M.D., Hartford, Conn.
    "The Physicians Role in Marital Maladjustment"

Proposed Amendments to the Constitution, MSMS

Presented to the MSMS House of Delegates on September 20, 1947

(These proposals will be presented to the MSMS House of Delegates in September, 1948, for final action)

ARTICLE I—NAME

Section 1. The name of the organization shall be the Michigan State Medical Society.

ARTICLE II—COMPONENTS

Section 1. This Society shall be made up of single County Medical Societies and Component County Medical Societies, now in affiliation with this Society or which may be hereafter organized and chartered by The Council of the Michigan Medical Society, provided that single County Medical Societies shall be a society of the physicians in one county; and provided further that Component County Societies shall be deemed to be an organization of the physicians of more than one county; and provided that when in the judgment of the House of Delegates it is deemed to be to the best interests of this Society, a charter may be granted to a society comprising the physicians of two or more counties. County Societies and Component County Societies hereafter in this Constitution and By-Laws will be called County Societies.

ARTICLE III—PURPOSE

Section 1. To bring into one organization the physicians of this State of Michigan, and through it and other state societies to form and maintain the American Medical Association.

Sec. 2. To maintain a program of educational service to the public on matters of health and hygiene.

Sec. 3. To encourage among members of the medical profession the interchange of views on all phases of medical advancement and to thus better equip each member of the profession to serve society and promote the public health.

Sec. 4. To maintain a program of scientific education for the members of the Society keyed to the constantly developing discoveries in the field of medicine; and to foster, encourage and co-ordinate postgraduate facilities for the medical profession as a whole.

Sec. 5. To disseminate advances in medical research among the profession generally by the issuance of scientific publications.

Sec. 6. To maintain and to advance the standards of medical practice in this state, both with respect to the highest concepts of ethics, and to the principles of scientific progress.

Sec. 7. To acquire and hold such real and personal property as may be necessary for the full and proper execution of the corporate purpose as detailed herein.

Sec. 8. To carry on such organization functions and activities as are deemed necessary to effectively accomplish the above purposes; provided, however, that the Socity shall engage in no activities that cannot be construed as relevant, incidental or necessary to its charitable, educational and scientific purposes.

ARTICLE IV—DIVISIONS

Section 1. This Society as a state unit of the American Medical Association, and as the state expression of the County Societies of Michigan shall have three major divisions.

1. The Society as a whole, as when it meets in general session.
2. The Scientific Assembly with its subordinate or related bodies.
3. The House of Delegates with its subordinate or related bodies.

ARTICLE V—MEMBERS

Section 1. This Society shall consist of active members, honorary members, associate members, retired members, members emeritus, and life members, elected in accordance with the By-Laws.

ARTICLE VI—THE SOCIETY AS A WHOLE

Section 1. The Society as a whole shall hold an annual meeting at such time and place and of such duration as the House of Delegates and The Council may determine. This power may be delegated to The Council by the House of Delegates.

ARTICLE VII—SCIENTIFIC ASSEMBLY

Section 1. The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine, its allied specialities and the problems of public health conservation.

ARTICLE VIII—HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Michigan State Medical Society and shall consist of Delegates elected by County Societies and Component County Societies.

ARTICLE IX—OFFICERS

Section 1. The officers of this Society shall be a President, a President-Elect, a Treasurer, a Secretary, an Editor, a Speaker and Vice Speaker of the House of Delegates, Councilors, Members of the House of Delegates of the American Medical Association, and Alternate Delegates to the House of Delegates of The American Medical Association.

ARTICLE X—THE COUNCIL

Section 1. The Council shall be the executive body of the Society. It shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and the House of Delegates between Annual Sessions.

Sec. 2. An Executive Committee of The Council shall consist of its Chairman, Vice Chairman, Chairman of the Finance Committee, Chairman of the County Societies' Committee, Chairman of Public Relations Committee, the President, the President-Elect, the Secretary and the Speaker of the House of Delegates.

ARTICLE XI—FUNDS AND EXPENSES

Section 1. Funds for meeting the expenses of the Society shall be raised by annual dues, special assessments and voluntary contributions.

Sec. 2. Annual membership dues and assessments shall be fixed by the House of Delegates.

ARTICLE XII—AMENDMENTS

Section 1. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published at least once during the year in THE JOURNAL of the Society, or sent officially to each County Society at least two months before the meeting at which final action is to be taken.

Sec. 2. This Constitution or any amendment thereto shall become effective immediately upon its adoption.

Proposed Amendments to the By-Laws, MSMS

Presented to the MSMS House of Delegates on September 23, 1947

(These proposals will be presented to the MSMS House of Delegates in September, 1948, for final action)

CHAPTER 1—MEMBERSHIP

Section 1. The charter of each County Society shall require that each of the provisions of the Constitution and By-Laws of this State Medical Society, together with each amendment to either thereof, hereafter adopted, in so far as the same is applicable, shall be an integral part of the Constitution and By-Laws of the County Society to which a charter is issued and shall in no way be inconsistent with the Constitution and By-Laws of the Michigan State Medical Society.

Sec. 2. The House of Delegates is empowered to revoke the charter of any County Society whenever it finds that such society has materially breached any of the provisisions of the Constitution or By-Laws of the State Society or has failed to function within the expressed spirit and purpose of the State Society, to such extent that revocation of charter is compatible with the best interests of the State Society. Petition for the revocation of charter of any County Society may be filed with The Council by a Councilor of the district within which such society is located, or by any three members of the County or the State Society or by the President of the State Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such petition together with written notice of the time and place of hearing on the petition shall be served on the affected County Society not less than sixty (60) days before the date of such hearing. The affected County Society may within thirty (30) days after service upon it of copy of the petition file with The Council a written answer thereto. The Council shall afford the affected County Society a fair hearing of the matters complained of, a suitable opportunity to present its defense and to be represented by counsel. Written arguments may be filed on behalf of the affected County Society and on behalf of the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter. The Council shall make its decision based on the records, setting forth in writing its finding of facts, conclusions and reasons therefore. If two-thirds of The Council do not concur in the conclusion that the charter of the affected County Society shoud be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of The Council concur in the conclusion that the charter of the affected County Society should be revoked, the Chairman of The Council shall transmit to the House of Delegates a report, consisting of the decision of The Council with records annexed, and shall serve a copy thereof on the affected County Society. The House of Delegates shall at the next regular or special session thereof following the transmittal of such report, but not less than sixty (60) days thereafter, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to The Council for further hearing and report. The action of the House of Delegates on the report of The Council shall be the final decision with reference to the revocation of the charter of a County Society.

Sec. 3. Each member of a County Society who is not in arrears as to dues and assessments shall be privileged to attend each meeting and take part in all the proceedings and shall be eligible to any office within the gift of the Society except as otherwise provided.

Any member in arrears for dues in the amount for one year or more may regain membership either by paying up all back dues or by being again elected to membership, at the option of The County Society.

For the purpose of determining the dues for new members only, the fiscal year of the Michigan State Medical Society shall be divided into four three-month periods. New members shall pay adjusted annual dues and assessments for the unexpired quarterly periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the State Secretary and such benefits shall not cover any period prior to their becoming members in good standing.

Sec. 4. In addition to the qualifications specified in their respective Constitutions and By-Laws, County Societies shall exact as qualifications for membership and its continued tenure, the acceptance and adherence to the Principles of Medical Ethics of the American Medical Association in accordance with the interpretation thereof by the Judicial Council of the American Medical Association, and such other qualifications as may be provided by this Constitution and By-Laws.

Sec. 5. No member who is under sentence of suspension or expulsion from any County Society of this Society, or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Society.

Sec. 6. Transfer of membership from one County Society to another shall be effectuated in the following manner:

The member who wishes such transfer shall make application to the County Society which he wishes to join, stating his reason for desiring a transfer of membership, which must include the fact that either his residence or office location is in the jurisdictional territory of that society, and tendering payment of dues for the remainder of the current year, calculated to the nearest quarter.

The Secretary of the County Society to which application is made shall request certification of standing from the County Society in which membership is then held. Upon receiving such request, the Secretary of the latter society shall supply certification of good standing, provided the following requirements have been met:

1. All County Society dues and assessments have been paid for the calendar year in which application for transfer was made.
2. County Society dues shall have been paid to cover that portion of the year preceding application for transfer, the time being calculated to the nearest quarter.
3. A member being granted a transfer shall not be under suspension or facing charges of unethical conduct.
4. In case the County Society dues have been paid in full for the year, and certification of good standing is being issued, the Secretary of the County Society shall refund County Society dues represented by the unexpired portion of the year, calculated to the nearest quarter.
5. Upon receipt of certification of good standing, and favorable action by the County Society to which application has been made, the transfer of membership requested shall be in effect.

Sec. 7. Resignation for transfer of membership to another state society shall be effected in the following manner:

Any member in good standing, not facing charges of unethical conduct, whose State and County Society dues and assessments are not in arrears, and who has moved his home or office to another state, may tender his resignation, which shall be effective at the beginning of the next quarter. Such resignation shall be transmitted to the State Secretary, who shall give the departing member certification of good standing.

Provided the portion of the calendar year following such resignation is not less than one-quarter, the Secretaries of the State and County Societies shall refund any dues and assessments already paid for the remainder of the year, calculated to the nearest quarter.

Sec. 8. Only active members are eligible to Retired, Emeritus or Life Membership. Transfers shall be by election in the House of Delegates. Requests for transfer shall be accompanied by certification by the Secretary of the State Society, as to years of practice and years of membership in good standing. The County Society of such members shall make request for certification, in writing, to the Secretary of the State Society thirty days in advance of an Annual Session.

CHAPTER 2—MEMBERS

Section 1. *Active Members*—Active Members shall comprise all the active members of County Societies. To be eligible for active membership in any County Society, each person must be under license to practice medicine, surgery and midwifery by authority of the Michigan State Board of Registration in Medicine.

Sec. 2. *Honorary Members*—County Societies may elect as Honorary Members any persons distinguished for their services or attainments in medicine or the allied sciences, or other services of unusual value to organized medicine or the medical profession. Upon recommendation of a County Society, the House of Delegates may elect such persons as Honorary Members of the State Society. Honorary Members shall pay no dues to the State Society and shall be without right to vote or hold office in either County or State Society.

Sec. 3 *Associate Member*—County Societies may elect as Associate Member:

1. Any person not a member of the profession but engaged in scientific or professional pursuits whose principles and ethics are consonant with those of this Society.
2. An intern serving the first year in any approved hospital, an intern of longer standing, a resident physician in training, a teaching fellow not engaged in private practice, but not after five years from the receipt of first medical degree (M.D. or M.B.).
3. A commissioned medical officer of the United States Army, Navy, Public Health Service and Veterans Administration on duty in this state who is not engaged in private practice of medicine.
4. A physician not engaging in any phase of medical practice.
5. A physician, resident of the State of Michigan, for the period of time he is in active military service of the United States previous to his engaging in active practice.
6. An active member, by transfer, for the period of time he is temporarily out of active practice on account of protracted illness.

Upon recommendation of a County Society, the House of Delegates may elect such person as Associate Member of the State Society. An Associate Member shall not pay dues in the State Society, nor shall he have the right to vote or hold office in either County or State Society.

County Societies may require an Associate Member to pay certain local dues, out of which THE JOURNAL subscription is to be paid to the State Society and for which such Associate Member shall receive THE JOURNAL.

Sec. 4. *Retired Member*—A member who has maintained his membership in a County Society of the State Society for a period of ten or more years, and who is certified by the County Society as having retired from practice, may be transferred to the retired members' roster. He shall be entitled to receive the publication of the Society at such rates as The Council may, from time to time, determine. He shall not have the right to vote or to hold office.

Sec. 5. *Member Emeritus*—Any physician who has been in practice for fifty years, and who has maintained a membership in good standing for twenty-five years, may, upon application and recommendation of his County Society, become a Member Emeritus. A Member Emeritus shall be relieved from paying State Society dues. He shall be entitled to all the benefits and privileges of membership.

Sec. 6. *Non-Resident Member*—County Societies may elect and retain as a Non-Resident Member any physician residing and practicing outside of the county who is a member in good standing of his own County Society. A Non-Resident Member shall not have the right to vote or hold office.

Sec. 7. *Life Member*—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

CHAPTER 3—GENERAL MEETING

Section 1. During each Annual Session the Society shall hold one or more General Meetings. The number and time of these General Meetings to be determined by The Council with or without the recommendation of the House of Delegates. Each General Meeting shall be presided over by the President or in his absence by the President-Elect or the Chairman of The Council. This meeting shall be called "Officers' Night."

Sec. 2. The following shall be the order of business in the General Meeting at which the reports of the House of Delegates are received:

1. Call to Order
2. Announcements and reports of House of Delegates
3. Retired President's annual address
4. Induction into office of Incoming President
5. Introduced of newly elected officers
6. Special addresses
7. Resolutions and motions

Sec. 3. Each registered Member at an Annual Session shall have an equal right to participate in the deliberations of a General Session and each Active Member, Member Emeritus and Life Member so registered shall have the right to vote on pending questions before the General Meeting.

Sec. 4. The General Meeting or any section of the Scientific Assembly may recommend to the House of Delegates or to The Council the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and the public. Such investigations and reports shall not become official action or expression of the Society until approved by the House of Delegates or The Council.

CHAPTER 4—HOUSE OF DELEGATES

Section 1. *Composition*—The House of Delegates shall be composed of delegates elected by the County Societies. Each County Society shall be entitled to send to the House of Delegates each year one Delegate for each fifty members and one delegate for each additional major fraction thereof. Any County which holds a charter from this Society and has less than fifty members shall be entitled to send one Delegate if its annual report has been properly filed with the Secretary.

Sec. 2. Officers of this medical Society and members of The Council shall be ex-officio members of the House of Delegates, and, with the exception of the Speaker of the House of Delegates, shall be without power to vote in the House of Delegates. The Past-President shall be a member at large of the House of Delegates during the first year of Past-Presidency with right to vote and hold office. All Past-Presidents shall have the right to the floor in the House of Delegates accorded to a regular Delegate without the right to vote.

Sec. 3. The House of Delegates shall transact all of the business of the Society not otherwise specifically provided for; it shall adopt rules and regulations for its own government and for the administration of the affairs of the Society; it shall provide for the organization of Councilor Districts, and, it shall provide for a division of the work of the Scientific Assembly of the Society into appropriate sections, adding new or discontinuing old sections.

Sec. 4. The House of Delegates shall meet annually at the time and place of the meeting of the Society as a whole in General Session, and may hold such number of meetings as the House may determine or its business require, adjourning from day to day as may be necessary to complete its business and specifying its own time for the holding of its meetings.

Sec. 5. A Delegate must have been a qualified Member of the State Society for at least two years preceding election or a Member Emeritus of the Society for at least two years preceding election.

Sec. 6. A Delegate once seated shall remain a Delegate through the entire session and his place shall not be taken by any other Delegate or Alternate, provided that in case of emergency the House of Delegates may seat a duly accredited Alternate from his County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by an accredited Alternate next on the list as certified by the Secretary of the County Society involved.

Sec. 7. The officers of County Societies shall certify to the State Secretary the names of the Delegates and Alternates who shall represent them at any Annual or Special Meeting.

Sec. 8. A quorum of the House of Delegates shall be constituted from 40 per cent of the accredited Delegates, providing that a majority of such quorum shall not come from any one County Society.

Sec. 9. The Officers of the House of Delegates shall be a Speaker and Vice Speaker. The Secretary of the State Society, elected by The Council, shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Meeting. The Speaker of the House of Delegates shall be a member of The Council and of its Executive Committee with right to vote.

Sec. 10. (a) The House of Delegates is the legislative body of the Society, and shall have authority to adopt and institute such methods and measures as it may deem most sufficient for the upbuilding and establishing of the interest of the profession in Michigan.

(b) It shall concern itself and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws and public health.

(c) It shall be active in the education of the public in regard to medical research and scientific medicine.

(d) Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the regulations of that parent organization and as hereinafter provided.

The number of Alternate Delegates shall equal the number of Delegates to the American Medical Association. Delegates and Alternates shall hold office for two years.

At each annual election, candidates for Delegates and Alternates shall be nominated in number equal to or greater than the number to be elected. Election shall be by ballot. The required number of high candidates shall be declared elected.

In case of a tie vote between any number of high candidates the winner, or winners, shall be decided by drawing lots supervised by the Speaker of the House of Delegates, provided, however, that any candidate thus tied shall have the right to a decision by ballot if he requests same.

The number of Alternate Delegates shall equal the number of Delegates. They shall be elected in exactly the same manner after all Delegates have been elected.

Alternate Delegates shall have relative seniority according to the respective number of votes received by them, and such seniority shall be designated at the time of election. Alternate Delegates serving their second year shall hold seniority over those Alternate Delegates serving their first year in office; provided, however, that re-election as Alternate Delegate shall carry with it no additional seniority.

Any vacancies caused by failure or inability of Delegates to attend shall be assigned to Alternate Delegates in order of their seniority as defined in this section.

(e) It shall divide the state into Councilor Districts.

(f) It shall have the authority to appoint committees, standing or special, from among its members or the members of the Society. Such committees are to report to the House of Delegates and their members may participate in the debate upon their committees' report.

(g) It shall approve each memorial and resolution in the name of the Society before the same shall become effective. Provided, that in the interim, in the presence of necessity for prompt action The Council is empowered to act in behalf of the Society.

(h) It shall elect the Councilors upon the nomination of the Delegates of the Councilor District whose Councilor's term expires.

(i) The House of Delegates shall provide for the division of the scientific work of the Society into appropriate sections. It shall prescribe the rules governing the meetings of these sections and the election of officers.

(j) It shall present a summary of its proceedings at a General Meeting of the Society and publish its minutes in THE JOURNAL.

(k) It shall have the following reference committees appointed by the Speaker: Committees on—

1. Council Reports.
2. Officer Reports.
3. Reports of Standing Committees.
4. Resolutions.
5. Reports of Special Committees.
6. Miscellaneous Reports.

(l) No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

(m) The election of officers shall be held at the last meeting of the House of Delegates at the Annual Session. Each nomination shall be made from the floor of the House. The Speaker having declared the nominations for any office closed, shall appoint tellers. In the event of having only one nominee, the candidate may be elected by a *viva voce* vote. Members elected to office shall take office with the induction of the Incoming President.

(n) Each resolution introduced into the House shall be in triplicate and presented to the Secretary immediately after the Delegate has read the same and shall be referred to the proper reference committee by the Speaker before action thereon is taken.

(o) Robert's Rules of Order when not in conflict with this Constitution and By-Laws shall govern the parliamentary proceedings of the House of Delegates.

CHAPTER 5—OFFICERS

Section 1. Officers shall be installed at the General Meeting at which the reports of the House of Delegates are received. They shall serve until the next Annual Session, provided that Councilors shall serve for five Annual Sessions, and provided further that not more than four Councilor terms expire normally at any Annual Session; provided further that Delegates to the American Medical Association may serve for two Annual Sessions.

Sec. 2. Officers shall serve until their successors are elected and inducted into office.

Sec. 3. At the Annual Session of this Society, next following his election, the President-Elect shall be installed into and assume the office of the President immediately following the annual address of the Retiring

President. He shall serve until his successor takes office. The assumption of office shall occur in General Session of the Society as a whole at which the reports of the House of Delegates are received. If no General Meeting is held at the Annual Session, the induction into office of the Incoming President and the newly elected officers shall be in the last meeting of the Annual Session of the House of Delegates.

Sec. 4. The President shall preside at each General Meeting of the Society, and shall fill each vacancy in office and committee with the advice of The Council unless otherwise provided for; he shall appoint the members of each committee not otherwise provided for; he shall deliver the President's Address; he shall have a voice in the deliberations of the House of Delegates and he shall be an ex-officio member of The Council with right to vote.

Sec. 5. The President-Elect shall be a member of The Council ex-officio, and shall act for the President in his absence or disability. If the office of President shall become vacant, the President-Elect shall succeed to the Presidency. If the office of President shall again become vacant, the Council shall elect a President for the unexpired term.

Section. 6. The Treasurer shall be the custodian of all the invested funds and the securities of the Society. He shall be elected by The Council and be accountable through The Council to the Society. The Council shall cause an annual audit to be made of his accounts.

Sec. 7. The Secretary shall be an active member of the Michigan State Medical Society and shall be paid a salary to be determined by the Council. He shall be the recording officer of the House of Delegates, The Council, Scientific Assembly, and General Session. He shall also discharge the following duties:

1. Collect all annual membership dues and such other moneys as may be due to the Society; keep membership records and issue membership certificates.

2. He shall make all required reports to the American Medical Association.

3. He shall deposit all funds received in an approved depository and disburse upon order of The Council. The Council shall cause an annual audit of his accounts by a certified public accountant. He shall render a report to The Council reviewing the Society's activities and imparting recommendations for the advancement of the Society's interest at each meeting of The Council.

4. Under the direction of The Council and with the advice of the Editor, he shall be the business manager of THE JOURNAL.

5. He shall superintend all arrangements for the holding of each meeting in compliance with the Constitution and By-Laws and instruction of The Council.

6. He shall send out all official notices of meetings, committee appointments, certificates of election to office and special duties of committees.

7. He shall receive and transmit to the House of Delegates and to The Council each committee and officers' annual report.

8. He shall institute and correlate each new activity under the supervision of The Council, and shall work on County Society integration and furnish information to the public concerning health matters as directed by the President and The Council.

The Executive Secretary, not necessarily a physician or a member of the Michigan State Medical Society, shall be appointed by The Council annually and shall be remunerated by a salary which shall be fixed by The Council.

The Secretary shall, with the approval of The Council, assign to the Executive Secretary such of the above duties as he deems advisable.

Sec. 8. The Speaker shall preside at sessions of the House of Delegates. He shall, with the approval of the President, appoint all committees created by the House of Delegates, unless otherwise provided, and shall perform such duties as custom and parliamentary usage require. He shall have a right to vote only when his vote shall be the deciding vote. He shall be a member of The Council and of its Executive Committee with the power to vote.

Sec. 9. The Vice Speaker shall assume the Speaker's duties in the Speaker's absence and shall have the right to vote when assuming such duties.

CHAPTER 6—THE COUNCIL

Section 1. The Council is the Executive body of the Society. It shall determine its own time and place of meeting. It shall elect its own Chairman and Vice Chairman to serve one year. It shall elect to serve one year, its Chairman, Vice Chairman, Chairman of the Finance Committee, Chairman of the County Societies' Committee, and Chairman of the Publication Committee; these with the President, the President-Elect, the Secretary, and the Speaker of the House of Delegates shall constitute the Executive Committee of The Council.

Sec. 2. Each Councilor shall be the organizer, peacemaker and censor for his District. He shall visit each County Society in his District at least twice a year and keep in touch with the activities of the societies constituting his District. He shall make such reports as the Chairman of the Council shall request concerning the condition of the profession in that District.

Sec. 3. Upon written complaint of at least half of the Delegates of the Councilor District involved, presented to the House of Delegates, in regular or special session, stating that the Councilor of said District has been remiss in his duties as prescribed above, and has been notified a month previously of this proposed action, the Speaker of the House shall bring the matter before the meeting for consideration. On two-thirds' vote of the House of Delegates this office shall be declared vacant and a successor elected.

Sec. 4. A member deeming himself aggrieved by an order of expulsion, suspension or other discipline made by his County Society, may appeal therefrom to The Council of the Michigan State Medical Society. Notice of appeal shall be in writing and set forth the specific reasons for such appeal. The notice shall be filed with said Council and a copy thereof served on the member's County Society. Unless such appeal is taken within thirty (30) days after service by registered mail, return receipt requested, of the copy of the order of discipline on the affected member, such order shall be final and effective. As soon as practicable after receiving copy of notice of appeal, the County Society shall forward to The Council a complete record of the case, which record shall consist of the petition, answer, testimony, order appealed from and all other pertinent writings and exhibits. The Council shall thereupon transmit such record together with the notice of appeal to the Committee on Ethics of the State Society for review. The Committee on Ethics shall promptly review the record and may request the County Society or the affected member to furnish such further proofs in writing as the Committee deems necessary for the proper and full review of the matter. Written arguments may be filed by the County Society and the affected member within such time as may be designated by the Committee on Ethics. The Committee on Ethics shall make its findings and recommendations in writing and report the same to the Council. The Council shall thereupon affirm, reverse or modify the order appealed from by written decision, a copy whereof shall be served on the County Society and the affected member. Unless, within sixty (60) days of the service upon him by registered mail of copy of such decision, the affected member takes an appeal to the Judicial Council of the American Medical Association, the decision of the Judicial Council shall be final and effective. Provided further that the County Society, aggrieved by the decision of The Council of the State Medical Society, may within sixty (60) days appeal to the Judicial Council of the American Medical Association.

Sec. 5. It shall make careful inquiry into the condition of the profession in each county in the state, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such County Society as already exists and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians in the same locality and shall continue these efforts until every reputable physician of the state has been brought under the Society's influence.

Sec. 6. It shall upon application provide and issue charters to County Societies organized in conformity with this Constitution and By-Laws and revoke such charters when deemed necessary.

Sec. 7. The Council shall direct and control the publication of THE JOURNAL.

Sec. 8. The Council shall elect a Secretary, an Editor of THE JOURNAL and a Treasurer at its annual meeting in January of each year. They shall take office immediately and serve for a term of one year, or until their successor is elected and takes office.

Sec. 9. The funds of the Society shall be disbursed only by order or action of the Council.

Sec. 10. Invested funds of the Society shall be delivered to the custody of the Treasurer by the Secretary.

Sec. 11. The Secretary shall collect annual dues, assessments and moneys owing the Society, placing them in a depository approved by The Council. He shall disburse them only upon order of The Council. The Council shall cause an annual audit be made of the funds of the Society by a certified public accountant and shall require the Treasurer and Secretary to give a bond in an adequate amount, this bond to be paid for from the funds of the Society.

Sec. 12. The Chairman of the Council, subject to its approval, shall appoint an Auditing Committee of three members, designating one of the members as its chairman.

The Auditing Committee shall inspect all bills and claims against the Society, and no bill or claim shall be paid except upon voucher or draft having the approval of at least two of the three members of the Auditing Committee. Provided, however, that any bill or claim may be paid without the approval of any member of the Auditing Committee by a majority vote or written approval of a majority of all the members of the Executive Committtee.

Sec. 13. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

Sec. 14. The Council shall render an Annual Report to the House of Delegates.

Sec. 15. The following County Societies shall constitute the Councilor Districts of the state:

First District—Wayne.

Second District—Eaton, Hillsdale, Ingham, Jackson.

Third District—Branch, Calhoun, St. Joseph.

Fourth District—Allegan, Berrien, Cass, Kalamazoo, Van Buren.

Fifth District—Barry, Ionia-Montcalm, Kent, Ottawa.

Sixth District—Clinton, Genesee, Shiawassee.

Seventh District—Huron, Sanilac, Lapeer, St. Clair.

Eighth District—Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola.

Ninth District—Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (including Antrim, Charlevoix, Cheboygan and Emmet), Wexford (Missaukee, Wexford).

Tenth District—Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Gladwin, Kalkaska and Ogemaw combined).

Eleventh District—Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana.

Twelfth District—Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger.

Thirteenth District—Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon.

Fourteenth District—Lenawee, Livingston, Monroe, Washtenaw.

Fifteenth District—Macomb, Oakland.

Sixteenth District—Wayne.

CHAPTER 7—STANDING COMMITTEES

Section 1. The following standing committees shall be appointed by the President with the advice of The Council:

(a) Committee on Legislation.
(b) Committee on the Distribution of Medical Care.
(c) Joint Committee on Health Education.
(d) Medical Legal Committee.
(e) Committee on Preventive Medicine.
(f) Committee on Postgraduate Medical Education.
(g) Committee on Public Relations.
(h) Committee on Ethics.

Sec. 2. The Committee on Legislation shall consist of a Chairman, the President-Elect of the State Medical Society and the Chairman of The Council of the State Medical Society and members to be appointed by the President with the advice of The Council.

The Committee on Legislation shall utilize every organized influence of the profession for the promoting of such legislation as will be for the best interests of the public's health and that of scientific medicine. It shall work under the direction of the House of Delegates or of The Council when the House of Delegates is not in session. No bill or proposed law or amendment shall be delivered to any member of the Michigan State Legislature for introduction in the name of this Society or by any of its committees until such proposed legislation shall have been endorsed and approved by The Council.

It shall submit an annual report with recommendations to the House of Delegates.

Sec. 3. The Committee on the Distribution of Medical Care shall consist of five members appointed by the President with the advice of The Council.

This Committee shall collect, analyze and distribute information, and advise Medical and other groups or individuals concerning Medical Economic Problems in Michigan. It may appoint sub-committees and seek information and co-operation whenever such action, in its judgment, is necessary to public welfare. It shall act as a central clearing house for the activities of Committees on the Distribution of Medical Care of the various County Societies throughout the state.

Sec. 4. The Medical Legal Committee shall consist of five members appointed by the President with the advice of The Council.

The Committee shall co-operate with the Medical Legal Counsel of each County Society in advising members as to their rights and duties in the practice of their profession.

It shall furnish upon application by any official Medical Legal Counsel of a County Society or a Councilor information and advice pertaining to the rights and duties of physicians in the practice of their profession.

Sec. 5. The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the advice of The Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944 the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term.

Sec. 6. Committee on Preventive Medicine shall consist of the Chairmen of the following Committees:

Committee on Cancer Control,
Committee on Maternal Health,
Committee on Venereal Disease Control,
Committee on Tuberculosis Control,
Committee on Industrial Health,
Committee on Mental Hygiene,
Committee on Child Welfare,

(Continued on Page 664)

MILESTONES IN CARDIORESPIRATORY HISTORY

Aretaeus

OF CAPPADOCIA (1st Century A.D.)

First accurate description of asthma;
separated asthma from orthopnea.
"If heart be affected,
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In the treatment of bronchial asthma,
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of anhydrous theophylline.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

SEARLE

RESEARCH
IN THE SERVICE
OF MEDICINE

(Continued from Page 662)

Committee on Heart and Degenerative Diseases,
Committee on Radio,
Committee on Postgraduate Medical Education,
Representatives to the Joint Committee on Health Education,
Such other committees as may from time to time be appointed to study and develop programs dealing with specific diseases,
The State Health Commissioner.

The Chairman of the Preventive Medicine Committee shall be appointed by the President, together with the members of all special committees, with the advice of The Council.

The duty of this committee shall be to collect, analyze and distribute information on preventive medicine, and to advise medical and other groups or individuals concerning problems in preventive medicine and public health.

Sec. 7. The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the advice of The Council. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term.

The duty of this Committee shall be to supervise for the Michigan State Medical Society all present postgraduate medical training in the state and, with the approval of the Executive Committee of The Council, make any changes, additions or discontinuances of present programs and initiate such new programs as they deem advisable.

Sec. 8. The Committee on Public Relations shall be appointed by the President with the advice of The Council. It shall be the duty of this committee: (a) to integrate and publicize all approved plans and projects emanating from The Council, the Executive Committee, and other standing and special committees of the Michigan State Medical Society; (b) to consider all plans and projects, and make suggestions and recommendations for improving or changing such plans for integration and publicizing; (c) to develop further plans for better physician-public contacts.

Sec. 9. The Committee on Ethics shall consist of eight members appointed by the President with the advice of The Council, each member to serve for a four-year term, so staggered that two members are selected annually. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term.

The Committee shall render advisory opinions on questions of ethics submitted to it by The Council.

On request of The Council it shall conduct an investigation, under rules approved by The Council, concerning the ethical conduct of a designated member of this Society and report its findings to The Council.

CHAPTER 8—REFERENDUM

Section 1. At any General or Special Meeting of the Society as a whole in General Session, it may by a two-thirds vote order a general referendum upon any question pertinent to the purposes and objects of the Michigan State Medical Society, organized medicine or the health of the public, provided, however, that a quorum at such General or Special Meeting shall consist of 300 members of the Michigan State Medical Society who are in good standing.

Sec. 2. The House of Delegates, by a majority vote of its members, may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, provided 300 members of the Society, in good standing, are present to constitute a quorum; provided further that two-thirds majority of the members present at such meeting shall determine the question and make it binding.

CHAPTER 9—SEAL

Section 1. The Society shall have a common seal. The power to change or renew the seal shall rest with The Council.

CHAPTER 10—EMERGENCY

Section 1. When prompt speech and action are imperative, authority to speak and act in the name of the Society is invested in The Council with the consent of the President.

CHAPTER 11—ANNUAL DUES

Section 1. The Secretary of each County Society shall collect and forward the dues to the State Secretary on or before April first of each year.

Sec. 2. Any member in arrears after April first of each official year shall stand suspended until his name is properly recorded and his dues for the current year properly remitted.

Sec. 3. Any County Society which fails to make the reports required at least thirty days before the Annual Meeting of the State Society shall be held suspended and none of its members or Delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

Sec. 4. An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately following such duty.

CHAPTER 12—COUNTY SOCIETIES

Section 1. All County Societies now in affiliation with the State Society or those which may hereafter be originated in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws or with the Principles of Medical Ethics of the American Medical Association, will upon application to The Council receive a charter and become a component part of this Society.

Sec. 2. Only one County Society shall be chartered in any county.

Sec. 3. Each County Society shall be the judge of the qualifications of its own members; but, as such societies are the only portals to this Society and the American Medical Association, each reputable practitioner of medicine who meets the requirements specified in the By-Laws, Chapter 2, Section 1, shall be eligible to active membership.

(a) A County Society may expel, suspend or otherwise discipline any of its members in accordance with the provisions of its constitution and by-laws; provided, however, that any member against whom such action is taken shall be accorded the benefit of the following procedures:

(b) Efforts at conciliation and adjustment of differences shall precede formal complaint against a member sought to be disciplined.

(c) Complaints against a member must be in writing and referred to the Ethics Committee of the County Society and shall set forth with reasonable particularity matters complained of.

(d) A copy of the petition, together with notice of the time and place of hearing, shall be served on the affected member not less than thirty (30) days prior to the date of hearing.

(e) The affected member may file with his County Society written answer within fifteen (15) days after service upon him of a copy of such petition. He shall be accorded a fair hearing of the matters complained of before the Ethics Committee of his County Society and afforded an opportunity to present his defense, either in person or by counsel.

(f) A stenographic record shall be made of the proceedings at the hearing, and in case an appeal is taken by such member, a transcript thereof shall be prepared at the expense of the County Society for transmittal to the State Society. In such case, a copy of the transcript shall be furnished to the appellant as soon as may be.

(g) Any order of expulsion, suspension or other dis-

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cipline of a member shall be in writing, and shall set forth findings of fact, conclusions and reasons therefore. A copy of such order shall be served on the affected member as soon as may be.

(h) No such order shall become effective until the affected member has had an opportunity to avail himself of his rights of appeal as provided in these By-Laws.

(i) In County Societies having a Council, the procedure shall be: Written complaint, hearing before the Ethics Committee, a reference to The Council for adjudication, appeal to the Society as a whole, appeal to The Council of the State Medical Society and appeal to the Judicial Council of the American Medical Association.

(j) Each complaint, hearing or decision must give member at least thirty (30) days notice for rebuttal.

Sec. 4. A member of a County Society whose license has been revoked shall be dropped from membership automatically as of the date of revocation.

Sec. 5. A physician living near a county line may hold his membership in that County Society most convenient for him to attend, on permission of the Councilor or Councilors in whose jurisdiction he resides.

Sec. 6. Each County Society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, the moral and material conditions of every physician in the county; systematic effort shall be made by each member and by the County Society as a whole to increase the membership until it embraces every eligible physician in the county.

Sec. 7. At the Annual Meeting of each County Society or at a designated meeting of which ample notice has been given, each County Society shall elect Delegates or Alternate Delegates in conformity with the provisions of this Constitution and By-Laws to represent the County Society in the House of Delegates of this Society. The Secretary of the County Society shall immediately send a list of its Delegates to the Secretary of the State Society.

A Delegate, or in his absence the Alternate Delegate, becomes a member of the House of Delegates when properly registered and seated at the Annual Session following his election by the County Society. His membership in the House continues until the next Annual Session.

Sec. 8. The Secretary of each County Society shall keep a roster of its members and if practicable a list of non-affiliated physicians in the county, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this state, and such other information as may be deemed necessary.

Sec. 9. Each County Society shall appoint or elect a Committee on Legislation and Public Relations, and the County Secretary shall send the name and address of the Chairman to the Secretary of this Society.

CHAPTER 13—DEFINITION OF SESSION AND MEETING

Section 1. A session shall mean all meetings at any one call.

Sec. 2. A meeting shall mean each separate convention at any one session.

CHAPTER 14—AMENDMENTS

Section 1. These By-Laws may be amended by a majority vote of the Delegates seated, after the proposed amendment is laid on the table for one meeting. These By-Laws become effective immediately upon adoption.

Michigan's Department of Health

G. D. Cummings, M.D., Acting Commissioner

MICHIGAN DOGS SOURCE OF SALMONELLOSIS IN MAN

Michigan dogs are frequent hosts of Salmonella organisms and should be considered as a potential source of Salmonellosis in man. This is revealed in a study being conducted in the Laboratories of the Department.

In an article entitled "Salmonella from Dogs and the Possible Relationship to Salmonellosis in Man" in the March issue of the *American Journal of Public Health,* Arthur H. Wolff, D.V.M., Norman D. Henderson and Grace L. McCallum report that fifteen Salmonella types, most of which are pathogenic to man, have been recovered from stools of eighteen of the 100 dogs examined in their studies.

The types identified were: *S. manhattan, S. newport, S. minnesota* (both monophasic and diphasic varieties), *S. oranienburg, S. typhimurium, S. bredeney, S. worthington, S. give, S. cubana, S. cerro, S. kentucky, S. illinois* and *S. meleagridis.* There were two types isolated to which the antigenic formulae of XXVIII: y and III, XV:z^{10} respectively were ascribed.

The pathological significance of these isolations has not been entirely ascertained, according to the authors, and additional work is being performed toward that end.

WELL WATER CAUSES CYANOSIS IN INFANTS

High nitrate concentration in well water should be suspected as the cause of methemoglobinemia among Michigan infants particularly if the water used for the baby's formula and drinking is from a dug well of poor construction.

Analysis of nine samples of water from dug wells suspected in cases of methemoglobinemia in Michigan Department of Health Laboratories showed that each had a nitrate concentration of 200 to 900 parts per million. The level of safety is less than 10 parts per million. Survey of the suspected wells revealed that they were, in all cases, shallow dug wells, improperly located and improperly constructed.

Methemoglobinemia gives the baby a cyanotic appearance not unlike that of congenital heart disease but heart pulsation remains normal, and circulation and respiration are unaffected in early stages.

Methemoglobinemia occurs when in the intestinal tracts of certain infants nitrates are changed to nitrites which are absorbed into the blood changing the hemoglobin to methemoglobin. Methemoglobin is not toxic but is unable to carry oxygen. The blood becomes chocolate to dark brown in color and the skin takes on a bluish-grey cast.

The cyanosis is slowly progressive or may be recurrent. The baby has only digestive trouble such as chronic diarrhea or constipation, with or without abdominal pain.

Spontaneous transformation of the methemoglobin to hemoglobin usually results when the nitrate contaminated water supply is withdrawn, but the disease can be fatal. Treatment of advanced cases involves the use of methelene blue and Vitamin C.

The Michigan Department of Health laboratories will test for nitrate concentration, samples of any water suspected of causing methemoglobinemia, submitted by practicing physicians.

The Department in May began testing some municipal supplies for nitrate concentration.

VISITOR FROM NORWAY

Sverre Stene, Chemical Engineer of the Norwegian Institute of Public Health, who is in the United States for 100 days to catch up on sanitation information his country missed while "behind the curtain" was in the Department three days during April.

ANNIVERSARY OF GOITER BATTLE

The twenty-fourth anniversary of the sale of iodized salt for table use in Michigan occurred May 1. Sponsored by the Michigan State Medical Society and the Department of Health, and with the co-operation of salt manufacturers, the first salt treated to assist in preventing simple goiter among children was sold in the state in 1924.

REGRESS TO RAW MILK

Two Michigan cities, Ypsilanti and Manistique, have voted to permit sale of raw milk within their confines. A section of the 1947 Pasteurization Act makes it possible for a community to defeat the purpose of the Act through electing not to come under its provisions. Petitions signed by ten per cent of the voters of a municipality can compel the governing body to place the question on the ballot at the next general election.

TUBERCULOSIS LAWS

The Department has assisted the Michigan Tuberculosis Association in preparing a pamphlet which discusses the free treatment and hospital care available to tuberculosis patients of the state. Each tuberculosis patient in the state should have a copy of the pamphlet, "Who Pays for Hospital Care and Treatment." Copies are available from the Michigan Tuberculosis Association or the Department of Health. Copies of the revised tuberculosis law are also available from these sources.

DIAGNOSTIC SERVICE IN VD CENTER

The Michigan Rapid Treatment Center, which last year treated 658 cases of syphilis referred to it by practicing physicians of the state, this year is increasing its services.

Physicians may now refer private cases to the Center for diagnosis and for recommendations for treatment.

(Continued on Page 670)

DIAGNOSTIC SERVICE IN VD CENTER

(Continued from Page 668)

The patient will return to the private physician for any necessary treatment.

Where such services are desired the physician should send a letter with the patient to the Center stating that consultation service only is desired and that he intends to treat the patient.

The Center has bed space available so that private physicians may refer for treatment, cases in the following diagnostic categories:

1. Syphilis
   - Primary
   - Secondary
   - Early latent
   - Syphilis in pregnancy
   - Early congenital
   - Late asymptomatic
   - Neurosyphilis (Asymptomatic only)
2. Gonorrhea
   - Gonorrhea with complications
   - Treatment resistant gonorrhea
3. Chancroid
4. Granuloma Inguinale
5. Lymphogranuloma venereum

The length of stay at the Center required for treatment of syphilis patients is normally two weeks. Physicians should tell their prospective patients that they will be at the center for at least two weeks.

During recent months there has been considerable number of referrals of symptomatic neurospyhilis to the Center. It is not the policy of the Center to treat symptomatic neurosyphilis and it is requested that such cases not be sent to the facility. The danger of Herxheimer Reaction tends to create a considerable problem with this type of case in the Center.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*April, 1948*	*April, 1947*
Diphtheria	4	22
Gonorrhea	658	834
Lobar pneumonia	80	108
Measles	6484	343
Meningococcic meningitis	13	18
Pertussis	285	746
Poliomyelitis	6	5
Scarlet fever	604	511
Syphilis	973	1236
Tuberculosis	628	481
Typhoid fever	4	3
Undulant fever	24	25
Smallpox	0	0

RABIES SITUATION SERIOUS

Rabies in animals continues at approximately the same rate as last year. There were ninety-two positive heads in the first four months of this year compared with 103 positive heads for the same period last year. The total number for 1947 was 332.

The ninety-two positive heads were from seventeen counties and the City of Detroit. Seven counties had asked for dog quarantines by May 1; namely, Ottawa, Cass, St. Joseph, Washtenaw, Wayne, Livingston and Lapeer. Three counties had compulsory vaccination as a prerequisite for licensing. These were Berrien, Van Buren and Kalamazoo.

There was no evidence that rabies had infected Michigan foxes by May 1, but during 1947 Ohio reported eighty-five positive fox heads and Indiana reported two positive fox heads. If rabies is not controlled in Michi-

gan, there is no doubt but that wildlife will be ultimately involved.

MEASLES CONTINUE

Measles continued to be reported at approximately 1500 cases a week. During the week ending April 30, there were 1483 cases reported. This brought the number of cases reported this year to 22,717.

By and large, the outbreak had died out in the southwest area of the State by May 1 and was concentrated in the Detroit and Wayne County area.

Communication

Wilfrid Haughey, M.D., Editor
Journal Michigan State Medical Society
Battle Creek, Michigan

I am submitting a brief manuscript for publication in your Journal.† It is a new vista on cancer—development of an anti-cancer biotic. One reason for selecting this Journal is that when I was an eager intern at the University of Michigan you published the first scientific paper I ever wrote. The chief reason is that this may well be the first in a series of articles over the years, and if Michigan men, those in practice in the State plus the University of Michigan researchers, become the basic unit, it is suitable for your JOURNAL to publish the first paper.

The idea of using a Cancer Cemetery as a glorified petri dish and culture medium to develop and ascertain what molds can or be taught to lyse cancer cells, so that from them an anti-cancer penicillin can be made, needs the triangle of: (a) city and country doctors, (b) university research, (c) industrial manufacture. All are in Michigan.

Respectfully,

HAROLD S. HULBERT, M.D.
Editor, Journal of Criminal Law and Criminology

†See "A Cancer Cemetery," page 628.

In Memoriam

MYRON WILLIAM CLIFT, M.D., Midland, Michigan. Born April 14, 1883, in Bay City, Michigan; graduated from the University of Michigan Medical School in 1905; well-known x-ray specialist. Dr. Clift served as associate professor of Roentgenology at the Detroit City College and as Consultant and Officer in charge of the Army X-Ray School in Paris, France, during World War I. He was the author of a number of articles on medical subjects appearing in medical literature, the most recent being that of "A New Nasopharyngeal Radium Applicator" for irradiation of the eustachian tube, which appeared in the September, 1944, issue of the *Archives of Otolaryngology*. He was a member of the Genesee County Medical Society, the American Medical Association and the Michigan State Medical Society; also the American Board of Radiology and the American College of Physicians. Dr. Clift died on May 7, 1948, in Midland, Michigan, at the age of sixty-five.

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E. GLENN McPHERSON, M.D., Detroit, Michigan. Born in 1895 in Indiana; graduated from the Indiana University School of Medicine in 1920. Dr. McPherson was a specialist in industrial surgery. He was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. McPherson passed on in February, 1948, in Detroit, Michigan, at the age of fifty-one.

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ADOLPH SHOENFIELD, M.D., Detroit, Michigan. Born in 1890 in Austria-Hungary; graduated from the Harvard Medical School in 1918. Dr. Shoenfield was a member of the Wayne County Medical Society, the American Medical Association, and the Michigan State Medical Society. Dr. Shoenfield died on November 26, 1947, in Detroit, Michigan, at the age of fifty-seven.

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ROBERT JAMES McCLURE, M.D., Calumet, Michigan. Born, 1908; graduated from University of Michigan Medical School, 1933. Dr. McClure was a specialist in ophthalmology, otology, laryngology and rhinology, a member of the Houghton County Medical Society, the American Medical Association and the Michigan State Medical Society. He was killed in the crash of a private plane at Larium, Michigan, on May 4, 1948, at the age of forty-one.

* * *

ERSON MILLS CUNNINGHAM, M.D., Cassopolis, Michigan. Born February 14, 1868 in Warrenton, Indiana; graduated from the University of Indiana in 1898. Further study was taken at the Rush Medical School in Chicago and Vanderbilt University. Dr. Cunningham was a life member and a past president of the Cass County Medical Society, a member of the American Medical Association and a former member of the Michigan State Medical Society. He was a specialist in ophthalmology, otology, laryngology and rhinology, and had been a practicing physician for fifty-seven years. Dr. Cunningham died of cerebral hemorrhage May 13, 1948 in Dowagiac, Michigan, at the age of eighty years.

RED CROSS BLOOD PLASMA PROGRAM

(Continued from Page 642)

Similar blood bank centers may be organized later in other places if the need is established by the local medical society, and hospitals with the proper co-operation of the nearest American Red Cross Chapter.

The fact that the supply of war surplus plasma will probably be exhausted sometime in 1948, warrants a careful consideration of this new source of blood and blood products. The medical profession might well weigh the advisability of giving its support to such a program.

R. S. MORRISH

. . . . . NEWS MEDICAL

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of April 21, 1948

• Monthly financial reports and bills payable were presented, studied and approved.

• $40,000 transferred from current Public Education Account and segregated in P. E. Reserves.

• Report made by Public Relations Counsel that MSMS has accomplished almost all of the instructions embodied in Resolutions adopted at the first Michigan Rural Health Conference.

• MSMS Secretary Foster authorized to make vigorous protest to Senators Vandenberg and Ferguson against designation of Doctors of Medicine as a special group for induction up to forty-five years of age, in preliminary prints of legislation yet to be introduced to reactivate Selective Service.

• Reports accepted from Chairman of MSMS Committee on National Emergency Medical Service concerning activities at AMA-E.M.S. Committee meeting, Chicago, April 5-6; from Legislative Committee; Child Welfare Committee; Maternal Health Committee's Advisory Committee on Therapeutic Abortions and Sterilization; Rheumatic Fever Control Committee; Permanent Conference Committee of MSMS-Michigan Hospital Association-Michigan Nurses Association from Special Committee on Basic Science Act administration; and from the Michigan Health Council's sub-committee on Program.

• Beaumont Memorial plans at Mackinac Island presented by W. F. Doyle, Vice Chairman of the Mackinac Island Park Commission.

• G. Don Cummings, M.D., Lansing, acting State Health Commissioner, discussed mutual problems and interests with the Executive Committee of The Council.

• Blue Cross vs. AMA coverage of its employes was thoroughly discussed and Editor Haughey was authorized to send a communication on this subject to MSMS membership via the Secretary's Letter. Proper contacts with the AMA authorities also authorized.

• Vote of thanks to H. H. Cummings, M.D., Ann Arbor and Grover C. Penberthy, M. D., Detroit on the success of the second Michigan Postgraduate Clinical Institute, was authorized; Dr. Cummings acted as Chairman and Dr. Penberthy as Vice Chairman.

• D. Bruce Wiley, M.D., Utica was re-elected as Michigan Chairman and MSMS representative to AMA Grass Roots Conference of June 20 in Chicago.

• Michigan's Delegates to AMA House of Delegates invited to attend May 19 Executive Committee meeting to discuss matters of national medical interest, prior to AMA session in Chicago, June, 1948.

• Liaison Committee with Michigan State Pharmaceutical Association appointed.

• Public Relations progress outlined by Mr. Brenneman, who was congratulated on his recent honor in being appointed Consultant in Public Relations by the State Bar of Michigan.

The United States Chapter, International College of Surgeons, will hold its 13th Assembly and Convocation in Kiel Auditorium, St. Louis, November 16-19, 1948.

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The American College of Physicians will hold its Annual Session at the Waldorf Astoria Hotel, N. Y. the week of March 28, 1949.

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Caesarian Sections.—The *Bulletin of the California Physicians Service* reports that California physicians are delivering 3,000 babies per year, of which 800 are caesarian sections.

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Irving I. Edgar, M.D., Detroit psychiatrist, was elected a Fellow of the American College of Physicians, at the annual session held in San Francisco, California, April 21, 1948.

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E. F. Sladek, M.D., Traverse City, President-Elect of the Michigan State Medical Society, addressed the Indiana State Medical Association on May 27 in Evansville. His subject was "The Modern Practice of Medicine."

Dr. Sladek also represented the Michigan State Medical Society at the Annual Session of the Illinois State Medical Society in Chicago the week of May 10.

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E. I. Carr, M.D., Lansing and L. J. Gariepy, M.D., Detroit, attended the Sixth Assembly of the International College of Surgeons in Rome, Italy, the week of May 18. Dr. Gariepy is Secretary of the United States Chapter, I.C. of S., and Dr. Carr is Vice Regent for Michigan.

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The Cover—Editor Wilfrid Haughey, M.D., Battle Creek, surrounded by recent covers of THE JOURNAL, MSMS. Under Dr. Haughey's progressive direction, JMSMS has attained a top position among state medical journals.

* * *

Members of the Kent County Medical Society were guests of the Pharmacy Association of Grand Rapids at

a baseball excursion to Detroit on June 17. The doctors travelled by charter bus to Detroit, inspected the Parke, Davis Laboratories, and spent the afternoon at Briggs Stadium (Tigers vs. Athletics).

* * *

Hugh W. Brenneman, MSMS Public Relations Counsel, spoke before the Van Buren County Medical Society on April 13, the South Haven Kiwanis Club on May 17, and the Optimist Club of Lansing on June 7. His subject in each instance covered the voluntary socio-economic activities of the medical profession designed to further the health of the people.

* * *

Orchid for the Michigan Postgraduate Clinical Institute: "Your recent Postgraduate Institute afforded me a most authoritative (and most hospitable and comfortable) way of keeping abreast of current clinical thoughts. I shall certainly hope to be present again next year if I am invited."—R. A. Kennedy, M.R.C.S., D.P.H., Medical Officer of Health, St. Thomas, Ontario.

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Ben E. Goodrich, M.D. and T. D. Johnson, M.D., both of Detroit, were guest speakers at the Fourteenth Annual Meeting of the American College of Chest Physicians, Chicago, June 17-20, 1948. Their subject was "Chronic Bilateral Basal Pulmonary Fibrosis."

William Tuttle, M.D. and George L. Waldbott, M.D., also of Detroit, were Discussants of other papers on the program.

* * *

When the American people went to war in 1917 to "make the world safe for democracy" they signed an IOU for nearly $400-billion. World War I cost $24-billion; World War II is estimated as close to $244-billion. Additional lend-lease and "loans" will bring the total almost to the $400-billion mark. By counting $3.00 every second and keeping it up for a little over 4,000 years, you'll get an idea how much money $400 billion is!

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, addressed the Medical Society of Northern Michigan in Petoskey on April 4. His subject was "Public Relations in Medicine." On April 15 Dr. Foster spoke to the Town Club of Lansing on "Medicine and Bureaucracy" with over 300 persons present at this dinner meeting.

Dr. Foster addressed the Alpena County Medical Society on April 29 on "Rheumatic Fever." On May 13 his talk to the Adrian Rotary Club was entitled "Our National Health Problem."

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Dr. Frederick F. Yonkman, Director of Research, Ciba Pharmaceutical Products, Inc., Summit, New Jersey, and Lecturer in Pharmacology and Therapeutics, Columbia University, College of Physicians and Surgeons, addressed the American Pharmaceutical Manufacturers' Association at their Pan-American meeting in Havana, Cuba, on April 14 on the topic "New Scientific-Medical Trends and Developments in the Pharmaceutical Industry." Dr. Yonkman also addressed the medical staff of the University of Havana on the subject "Influence of Sympatholoytic Drugs on Vascular Diseases."

Psychiatric Patients in Hospitals.—At the end of 1946, 529,247 persons, or *382.4 out of every 100,000* in the civilian population of the continental United States, were in hospitals for the prolonged care of psychiatric patients according to figures of the Mental Hygiene Division of the Public Health Service. The number of resident patients increased during the year by 10,575, representing about 2 per cent of the 518,672 present at the beginning of the year. The number of first admissions to prolonged care hospitals during 1946 was 153,025, or 110.6 per 100,000 of the estimated civilian population as of July 1, 1946.

* * *

T. E. DeGurse, M.D., Marine City, Michigan's Foremost Family Physician, was honored by the physicians of the Seventh Councilor District at a dinner meeting in Bad Axe on April 27. The honor guest has been longtime Councilor of the Seventh District. R. C. Dixon, M.D., of Pigeon, President of the Huron County Medical Society, acted as toastmaster and introduced P. L. Ledwidge, M.D., Detroit, President of the Michigan State Medical Society and MSMS Councilors W. E. Barstow, M.D., St. Louis and F. H. Drummond, M.D., Kawkawlin, each of whom spoke of the accomplishments of Dr. DeGurse during a long life of medical service to his community.

* * *

The Washtenaw County Medical Society authorized its President to appoint a Committee, to be known as the "Medical Service Committee" the duties of which are to receive the names of all physicians willing to accept off-hours calls, and to list them according to location (Ann Arbor area, Ypsilanti area), to supply said list periodically to the various hospitals in Washtenaw County, the County Health Department, the Nurses Bureau, and to all doctors of medicine in the county; the Committee will re-list its physicians in this category in September of every year; and finally, all complaints on medical service will be referred to the Medical Service Committee.

* * *

Michigan's census continues to climb in spite of the fact that there were less births during the first quarter of this year than there were in the same period of 1947.

Births, during the first quarter of 1948, exceeded by 20,716 the deaths during the same period, according to Department figures.

First quarter births numbering 35,214, exceeded by 5,994 the five-year average for the quarter, but fell 3,618 short of the record first quarter which was in 1947. The record quarter for births in the state was the final quarter of 1946 when 44,675 were reported.

Deaths for the first quarter of 1948 totalled 14,498. The five-year average was 14,425, and last year's first quarter figure was 14,585.

* * *

A. M. Hume, M.D., Owosso, was honored with a testimonial dinner by his community on Tuesday, May 4, 1948. The oldest living Past President of the Michigan State Medical Society (1918-1919) was acclaimed by Kenneth F. Crawford, Owosso's Mayor, G. W. Ben-

nett, M.D., President of the Shiawassee County Medical Society, and by W. E. Barstow, M.D., St. Louis, Vice Chairman of The Council, Michigan State Medical Society.

Hardy A. Kemp, M.D., Dean, spoke in behalf of Wayne University College of Medicine, Dr. Hume's alma mater.

Dr. Hume was born in 1859 and has been practicing medicine since 1881. Over 300 persons from all walks of life gathered to do honor to Dr. Hume, a practicing physician in Owosso for over sixty-seven years.

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Antihistaminic Drug.—Dr. Nathan Sperber, speaking at the annual meeting of the Division of Medicinal Chemistry of the American Chemical Society at the Hotel Hamilton, Chicago, described Trimeton, which has been extensively studied by leading allergists from coast to coast and found less toxic than the older products so far marketed. Although basically different in chemical structure than all other recently discovered antihistaminics, Trimeton has proved its effectiveness in hay fever vasomotor rhinitis, urticaria and other allergic states.

Experiments in the laboratory have shown that Trimeton in comparison with other known antihistaminics represents a major advance in the field of the "anti-allergic" drugs because it is low in toxicity, high in potency, and relatively free from those properties which from clinical experience with other drugs would be expected to exert undesirable side effects in human patients other than antihistaminic.

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Infant Mortality.—The infant mortality rate in 1946 was 33.8 deaths under 1 year per 1,000 live births, or 11.7 per cent less than the rate of 38.3 in 1945, according to figures of the National Office of Vital Statistics. The number of infant deaths which occurred during 1946 was 111,036, or 6,379 more than during 1945. This rise reflects the tremendous increase in the number of births during 1946. The relative frequency of infant death, as measured by the infant mortality rate, decreased.

The infant mortality rates shown here are the number of deaths under 1 year of age during a given year per 1,000 live births which occurred during that year. This rate is influenced by changes in the annual number of births. In years such as 1946, in which the number of births increased appreciably from the preceding year, the rate is understated.

The five leading causes of death during infancy, and the infant mortality rate in 1946, were: premature birth —12.1, congenital malformations—4.5, pneumonia and influenza (combined)—3.8, injury at birth—3.6, diarrhea, enteritis, and ulceration of the intestines (combined)—1.7.

* * *

The U. S. House of Representatives reduced the appropriation for the Office of the Social Security Commissioner from $3,131,165 to $221,000 with large reductions in funds for research and informational services. This was accomplished by the transfers of various activities to the Federal Security Administrator and operating divisions. In effect, this would involve a major re-

organization of the Social Security Administrative structure.

As compared with a requested appropriation of $3,131,165, the House allowed a total of $2,573, 549 of which all but $221,000 was transferred either to the Federal Security Administrator or to operating bureaus.

The bill is now in the U. S. Senate.

Representative Dingell criticized the reduction in the research staff (headed by I. S. Falk) from fifty to twenty employes, as follows:

> "The Bureau of Research and Statistics is at one and the same time the brain, the heart, and the nerve center of the social security program. This office conducts the basic studies necessary to analze the existing coverage of social security and the deficiencies and mistakes that may become apparent at operating levels. It supplies the committees of Congress with information upon which to legislate and to appraise the need for expansion of social security coverage. To reduce this research staff from fifty to twenty employes can be justified only upon the assumption that a Republican Congress either is not going to enact any progressive social security legislation or that they want to legislate in an uninformed vacuum."

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Mr. Henry L. Black, of Battle Creek, of the Professional Management, gave a series of three lectures to the first-year interns and young doctors at the University of Michigan in May on the "Business Side of Medicine."

This was a part of the course on Economic Medical Education sponsored by the Michigan State Medical Society.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

20,000 YEARS OF SERVICE. A photographic and biographic account of members of the Medical Society of the State of New York who have practiced forty years.

The Medical Society of the State of New York has bestowed upon each member who has practiced medicine for fifty years a certificate signed by the president. There are 432 physicians in New York State who have practiced for more than fifty years. A booklet has been published giving the picture before and after of forty-eight members, and pictures of 322 members who did not supply early pictures. Each of these pictures was accompanied by a short biography. This is a very interesting and valuable memento.

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HISTORY OF THE MEDICAL SOCIETY OF THE COUNTY OF WESTCHESTER 1797—1947. A compilation from the available minutes of the Society and various contemporary sources during the years for which the minutes were lost. Published by the Medical Society of the County of Westchester, 1947.

The Comita Minora of the Westchester County Medical Society of the State of New York authorized the publication of a history of the society at the 150th Anniversary. The volume produced is worthy of the effort, making a storehouse of historical information which might have become lost—the actions of the society, its officers, its representatives in military service. Varied

interests are indicated by the note in 1923 "On January 11, French and Belgian troops began the occupation of the Ruhr. In Westchester County an epidemic of measles and scarlet fever was reported by the Public Health Committee to the Society." Again, in 1923: "It is interesting to note here that on March 9, of this year, was ended the revolt in Bavaria organized by General Ludendorff and Adolph Hitler in Munich. Ludendorff was captured when the Beer Putschists marched, Hitler wounded." This book is full of interest and references, a pleasure to read.

ENCYCLOPEDIA OF MEDICAL SOURCES. By Emerson Crosby Kelly, M.D., F.A.C.S., Associate Professor of Surgery, Albany Medical College; Attending Surgeon Albany Hospital; Editor, Medical Classics. Baltimore: The Williams & Wilkins Company, 1948. Price, $7.50.

This book is unique. The author, in his preface, tells of helping his chief publish a book, Surgical Diagnosis, and misplacing McBurney's point. When discovered, a search showed 50 per cent of references made the same mistake. He noticed references to a certain sign "Homan's sign," and could not find it. Therefore, for many years, he has kept a list of references, and has compiled a valuable book of nearly 500 pages, two columns, containing an alphabetical list of names, giving the address, and classification as physician, physicist, surgeon, et cetera, then a description of the "test," "operation," "sign," "method," disease," "theory," "law," "technic," "medium," or whatever term is required. Almost everything imaginable dealing with medical matters is included, with

the reference to publication. This volume would be invaluable in a reference library, or for anyone who is a close reader of medicine.

BRIEF PSYCHOTHERAPY. A Handbook for Physicians on the Clinical Aspects of Neuroses. By Bertrand S. Frohman, M.D., with the collaboration of Evelyn P. Frohman. Forward by Walter C. Alvarez, M.D. 260 pages. Philadelphia: Lea & Febiger. 1948. Price, $4.00.

This handbook of treatment "was planned and written to aid physicians in detecting and managing the underlying psychological factors which are masked by functional disturbances." This volume contains brief descriptions of a large number of syndromes of emotional and psychosomatic illnesses. The large number of syndromes discussed necessitates very brief treatment of any one syndrome and makes the presentation of illustrative case material so brief that it is almost inadequate.

Careful study of the book should give a general practitioner a speaking knowledge of the subject, but this reviewer doubts that any good understanding of the basic principles involved can be presented in a handbook of this sort. It can be said that the material is presented in an interesting and readable fashion. This reviewer is in emphatic agreement with the thesis of the book, i.e., that the general practitioner and the internist should have an understanding of the basic principles of psychosomatic illnesses. On the other hand, the well-trained psychiatrist can and should take issue with the implication in the foreword that only the general practitioner or the internist is in a position to understand and treat psychosomatic disorders.

F. O. M.

BULLETIN, AMERICAN COLLEGE OF RADIOLOGY. Chicago, 1948.

This is an annual book listing the officers, committees, medalists; president's address and reports of the committees and commissions; the Constitution and By-Laws; a roster of the members, fellows and life members, also a geographical listing.

PSYCHOBIOLOGY AND PSYCHIATRY. A Textbook of Normal and Abnormal Human Behavior. By Wendell Muncie, M.D., Practicing Psychiatrist; Chairman, Medical Advisory Board, Seton Institute, Baltimore, Md.; Associate Professor of Psychiatry, Johns Hopkins University; Consultant in Psychiatry, U.S.V.A. Second Edition. With 70 illustrations. St. Louis: The C. V. Mosby Co., 1948. Price, $9.00.

The second edition of Psychobiology and Psychiatry brings a revised edition of a basic test in psychiatry. Dr. Muncie was a long-time associate of Adolph Meyer and is probably one of his outstanding disciples. The contributions to American Psychiatry by Dr. Meyer and his group are numerous and of considerable value and the revision of this textbook describing Dr. Meyer's approach is a welcome addition to the physician's library.

There are a number of important and significant changes. The bibliography throughout the volume has been revised and brought up to date and includes certain divergent viewpoints. The newer army classification of psychoneurotic disorders is included and compared with that of Kraepelin, Freud and Meyer. There are certain changes in the chapter on psychoneurosis as well as a new chapter on the psychosomatic disorders. In the section on treatment certain significant additions will

also be found. These include chapters on shock treatment, mental hygiene and on treatment of the convulsive disorders. An interesting subsection enumerates criteria for hospitalization as the method of choice in treatment. In summary one can say that the additions and revisions have added considerable to the value of an important and basic textbook. F. O. M.

MALE HORMONE THERAPY. A Refresher Course. Free upon request. Summit, N. J.: 1948. The Ciba Pharmaceutical Products, Inc.

This is a compilation of recent and reliable articles in standard medical publications. It is designed to provide a comprehensive reference to the experimental work as well as the therapeutic uses of the male sex hormone.

THE ACUTE BACTERIAL DISEASES.—Their Diagnosis and Treatment. By Harry F. Dowling, M.D., F.A.C.P., Clinical Professor of Medicine, George Washington University; Chief, George Washington Medical Division, Gallinger Municipal Hospital. With the Collaboration of Lewis K. Sweet, M.D., Chief Medical Officer in Pediatrics and Infectious Diseases, Gallinger Municipal Hospital; Adjunct Clinical Professor of Pediatrics, George Washington and Georgetown Universities; and Harold L. Hirsh, M.D., Assistant Professor of Medicine, Georgetown University; Director of the Bacteriology and Immunology Laboratory, Georgetown University Hospital. 465 pages with 55 figures. Philadelphia and London: W. B. Saunders Company, 1948. Price $6.50.

The book starts off with a general consideration of diagnosis of acute bacterial disease and general measures in treatment of infectious diseases. Serum therapy, the sulfonamides and their use in therapy, are followed by similar consideration of penicillin and streptomycin. The rest of the book is devoted to the diseases caused by cocci, by bacilli, and the bacterial diseases in which

exotoxins are the most important factor, such as diphtheria, tetanus, gas gangrene, et cetera. A very useful book, precise in its analysis of disease, and in treatment.

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TAKING THE CURE: The Patients Approach to Tuberculosis. By Robert G. Lowell, M.D. University Hospital, University of Michigan, Ann Arbor, Mich. Illustrated by Donald Gooch. New York: The Macmillan Co., 1948. Price $2.00.

This is a small book, written for the tuberculous patient who has just entered the hospital, or whose condition has just recently been diagnosed. The author describes the technique of living in bed, how to get along with other persons likewise hospitalized and undergoing strange controls. It tells the patient what is expected of him, and makes his co-operation less irksome.

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A.D.A. FORECAST. A new monthly magazine published by the American Diabetes Association for the general public.

This copy contains several articles, written for easy lay reading, by such men as Elliott P. Joslin, Herman O. Mosenthal, and Joseph H. Barach. Also other articles by laymen or dietitians. Pocket size and easily carried or referred to.

DERMATITIS FROM WEARING APPAREL

(Continued from Page 628)

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Classified Advertising

WANTED—Doctor to locate in Thompsonville, Michigan. General practice opportunity excellent. Good roads, two railroads, modern conveniences. Several smaller communities within radius of 20 miles. Population 350. Hospital facilities at Frankfort, Traverse City, Manistee—within 30 miles. Housing facilities good. No doctor practicing here at present time. For further information, contact Thompsonville Chamber of Commerce.

WANTED—Young physician especially trained in general and traumatic surgery to become associated with a group well established in metropolitan area of Detroit. Salary at least $6,000 a year, with a guarantee of $10,000 a year, and the position will lead to partnership. Write THE JOURNAL, Michigan State Medical Society, Box 47, 2020 Olds Tower, Lansing 8, Michigan.

TOWN of 500 people in a lucrative dairy community needs a physician badly. None within a radius of 10 to 35 miles. Housing available. Peck is considered the busiest little town in the thumb district. For further information, contact Mrs. C. E. Raft, 105 East Lapeer Avenue, or phone 3701 or 9131, Peck, Michigan.

PRACTICE FOR SALE—An eye, ear, nose and throat practice of twenty-five years' duration in Alpena, Michigan. Office fully equipped. Reason—death. Write or phone for appointment. Mrs. W. B. Newton, 715 Washington Avenue, Alpena, Michigan. Phone 238.

FOR SALE—Nine modern fully equipped Simmons hospital beds with Beautyrest mattresses, matching dressers, night stands and chairs: fracture equipment, six bassinets and frame. To highest bidder immediately. Contact Doctor C. L. Penoyar, South Haven, Michigan. Phone: 825.